		For State Registrar	State of	Maryland /		tment of H ificate of		d Mental Hy	giene	05	035	01
Dhyo	icion	1. Decedent's Name (First, Middle, L.	ast)			7		2. Date of De Month	ath Day	Year	3. Time of D	Death
	ician dical	IRENE SHIRLEY FR	RIES						7 13, 2		8:10	\mathbf{A}^{M}
	niner	4a. Facility Name (If not institution, gi		·		4b. City, Town, o	or Location of D	Death	4c. Count	y of Death		
		ANNE ARUNDEL MED				ANNAPOI				ARUN		
Funer Direct		5. Social Security Number 6. 188–26–2459	Sex 7 1□M 2▼F	. Age (In yrs. last 70		If Under 1 Year Months Days		Min. 8. Date of Bird (Month, Da MAR 21	y, Year)	Cour	lace (State or itry) ISYLVAN	
pu .		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loca	ation				1.	0d. Inside City	z Limita
sho	5		mm I a								1 ☐ Yes	
the A	Director	MD QUEEN A	INNE 2	CHES	IEK	10f. Zip Code			10g. Citizen of	What Cour		
3a or	ā	1905 BAYSIDE DRI	VE			21619			USA		, .	
death ma 2:	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.S.	13. Wa	as Decedent of H	lispanic Origin	? (Specify Yes or No	- 14. Ra	ce - Americ		
be filed within 72 hours after death with the Maryland tal Hyglene. It al Hyglene do the man 23a or 28a-f show awant, the Maryland remark to the Maryland awant, the Marical Evantier must be notified at	E.	1 Never Married 2 Married	Armed Ford 1 Tes 2 tf Yes, Give	X No	ì	res, specnry Cub ⊐Yes 2 X No		uerto Rican, etc.)		ıck, White,	etc. HITE	
ural',	d bv		Year or Dat	es:	1	1103 224110	Зреспу.		Speci	iy.	111111	
nat	Completed	15. Decedent's 8 (Specify only highest g	Education rade completed)	16	(Give ki	nt's Usual Occup nd of work done O NOT use retire	during most of	working	16b. Kind of E	Business/Ind	dustry	
withir Pan Chan	a m	Elementary/Secondary (0-12)	College (1-4				,		COMPT	men c		
Hygir L	S	17. Father's Name (First, Middle, Las	it)		DAIA I	ENTRY OF	,	Name (First, Middle,	Maiden Suma			
ine, intally identified within 72 hours after death with the Marylan if Health and Mental Hygiene. It has a second of the the Warylan Item 23a or 28a-1 show other treatmentic avant, the Medical Evanther must be notified at	To Be	DAVID C. RITCHIE						FAZEKAS		o f		
should I		19a. Informant's Name/Relationship		1	19b. Mailing	Address (Street		r Rural Route Number	or, City or Town	, State, Zip	Code)	
and 2 and 2 salth a n 27 ia		PAUL A. FRIES, J	R./HUSBAI	ND I	1905 I	BAYSIDE	DRIVE,	CHESTER,	MD 216	19		
of He of He roths		20a. Method of Disposition 1 Burial 2 X Cremation 3		20b. Place	of Disposit	tion (Name of tory or other pla		Date	20c. Location	- City or To	wn, State	
Pages nent of I ant: # its		`4 □Donation 5 □ Other (Spec			PEAKE	CREMAT	ORY 01	/14/2005	STEVEN	SVILL	E, MD	
permit. Pages: Department of himportant: if its any injury or of	once.	21. Signiture of Fun Service Lice	ense	7/		Name and Addre		EIN & NEWN				۸
40.5 6	a	Ch M-	11-1	<u> </u>	106	SHAMRO	CK ROAL), CHESTER	, MD 2	1619		
		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplications the cau y one cause of eac	used the death. Doth line.	o not enter	the mode of dyla	ng, such as car	diac or respiratory ar	rest,		Approximate Interval Betwoonset and De	reen
Physicia	_	Immediate Cause (Final disease or condition resulting in death)	_a. 2 Ca	rdine	ar	rest				4	Went	ds
/Medic Examin	_	resulting in death)	Due to (o	r as a consequenc	ce of):	1. 1		,,				
	e e	Sequentially list conditions,	b. Due to lo	r as a consequence	ce of:	and	delin	n			yes	
uted d ansit	-	cause. Enter Underlying Cause (Disease or injury that initiated events		non	do	case					m	
exec an an rial-tr	Examin	resulting in death) Last	Due to (or	r as a consequence								
cate be executed physician and the burial-transit	dical		d									
	Ved	IF FEMALE:										
ath ce ttendii	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	ome of pregnancy h 2 D Fetal dea	ath 3 □E	ctopic pregnanc	y			ate of delive		ear
the a	Sic	1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnar 9□Unknow	nt at time of death in	5 🗆 0	Other (specify) _			IV.	OH III I	Day 16	741
ires that the death certific signed by the attending for the detached for use as	F	Part II. Other significant conditions	contributing to dea	th but not resulting	a in the und	erhina cause an	ven in Part I	23a Did to	obacco use con	tribute to th	e cause of de	ath?
sign d be	φ		3		g	only mig outdoor give				3 ☐ Prob		
w require been si should	ete							24a. Was	an 24h	Wore auto	neu findinge a	vailable
The lave cate has page 2:	Completed							autop perfo	rmed2	prior to cor death?	psy findings av	use of
vician: Th certificate rector, pag	S	25. Was case referred to medical					OC Diseased	1 ☐ Yes Death (Check only o	2 No	1 🗌 Yes	2 No	
ysician: ysician: is certific director,	0 8	examiner? 1 Yes 2 No	Hospital:	patient 2 ER/	Outpatient	3□ DOA Oth	or	ng Home 5 Resid		ner (Snecifi	,)	
ding Ph h. After thi	i i	27. Manner of Death	28a. Date of		b. Time of Injury	28c. Inju	y at	28d. Describe h			,	
ath.	atio	1 Natural 5 Pending 2 Accident investigate	on	Day real/	Пјагу		Yes 2□No					
r Attandition of the street of	Certification:	3 Suicide 6 Could not determined	4 286. Place o	f Injury - At home, p, etc. (Specily)	, farm, stree	t, factory, office		28f. Location (S City or Tox		ber or Rura	Route Numb	er,
urs aft	Cer											
Hosp 24 hot Funa stely fi	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the b miner: On the bas and manne	is of examination	dge, death o and/or inve	occurred at the tir stigation, in my o	me, date and popinion, death of	lace, and due to the occurred at the time,	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)	
To this Hospital or Attanding Physician: The law requires that the death certification 24 hours after death. To this Furnatial Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Med	29b. Signature and title of certifler	and marine	statou.		29c. Licens	e number		29d. Date signe	ed (Month,	Day, Year)	
F ≶ F Ö) (/(n	- M	>		D383	กร		1.			
_	,	30. Name address of person who	completed cause	of death (Item 23)	a) (Type, Pr	int)	-		- /	10/0		
314		TONATHAN	AUTS	come	20	02 ME	DPKI	My AT	NN	1)	214c	/
	State	31. Date filed (Month, DANan)	1 2005 ^{32. Res}	trar's Signature	K :	had .		vy Ar				
Heal	strar				~ 44							

			Please	Type or Print in Bl				-	_	
			For State Registrar	State of Maryland	•	nent of F cate of i		, ,	ene g. No. 🤈 🗎 🕦 E	ring one
	Physic /Medi Exami	cal	Decedent's Name (First, Middle, Last Jean 4a. Facility Name (If not institution, give	n Frances Fri	end		r Location of Death	2. Date of Death		3. Time of Dealth
	Funeral			7) Age (In yrs. Ia.		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 24,	Year) 9. Bir 1923 Mar	thplace (\$tate or Foreign ountry) Yland
	Director		220-16-6025 Usual Residence of Decedent 10a. State 10b. County		Town or Location	on .		may 241	1925 Mar	10d. Inside City Limits
	e Maryla 8a-f sho	Director	MD Garrett		ident					1∕2 Yes 2 □ No
	th with the 23s or 2	ai Dire	10e. Street and Number 109 Wood Street		1	0f. Zip Code 2]	1520	10	g. Citizen of What Co USA	ountry?
36	72 hours after death with the Maryland naturel; or Items 23a or 28a-f show Jisal Examinar must be notified at	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 25 No If Yes, Give Year or Dates:	If Ye	Decedent of H s, specify Cuba Yes 2 No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	city Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify:	
21215-0036	Ithin 72 hou ie, ien "nature Medical E	npleted	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)		of work done IOT use retired	ation during most of workii d)	ng 1	6b. Kind of Business	Andustry
and 21	t be filed wintal Hygien ed other the	Be	12 17. Father's Name (First, Middle, Last)		Homemak	er	18. Mother's Name	_	Own Home	,
Maryland	12 should and Mei 7 Is mark reumatic	J.	John Shoemaker 19a. Informant's Name/Relationship (l Route Number,	City or Town, State.	
altimore, I	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importent: If Item 27 is marked other then "naturel; or Items 23s or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at ance.		Claudia J. Hook/d 20a. Method of Disposition 1 KBurial 2 Cremation 3 C 4 Donation 5 Other (Specify	Removal from State 20b. Pla	107 Wood ace of Disposition metery, cremato Paul's	n (Name of ry or other plac	(e)	ate 2	yland 215 Oc. Location - City or Accident,	Town, State
Balt	permit. Departr Importe any inj			euroa	New P.C	Box :	neral Home 275; Grant	sville,		21536
	Pnysician /Medical Examiner		23a. Part 1. Enfor the disease, or dom shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	Congress	ce mi s		ng, such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) C. Due to (or as a consequence)						
3760,		cai		_ d	arice or).					
.O. Box 68	ath certif ittending or use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant all time of dea 9 □ Unknown	death 3□Ect	opic pregnancy ner (specify)	,		23d. Date of de Month	llivery Day Year
۵.	uires that the de signed by the a Id be detached f	by	Part II. Other significant conditions of	•	ting in the under		en in Part I. Qcul	23e. Did toba		o the cause of death?
Vital Records,		Completed	Urosepsis	Coruna		tery	Di Seasi	24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of s 2 \(\sigma\) No
r Vita	Physicien: The la r this certificate has ral director, page 2	To Be (25. Was case referred to medical examiner? 1 ☐ Yes _ 2 ☐ No	Hospital: 1 Impatient 2 E	:R/Outpatient 3	DOA Oth	26. Place of Death er: 4 \(\sum \) Nursing Hor		nce 6 Other (Spe	əcify)
ion of	ding Afte fune		27. Manner of Death 1 Alatural 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time of Injury	28c. Injur Wor vi 1 🗆	yat 2 k? Yes 2 □ No	28d. Describe how	w injury occurred	
Division	i ji ji	Certification;	3 Suicide 6 Could not b 4 Homicide determined		ne, farm, street.	factory, office	2	28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
	24 h 24 h Fur etely	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of my know miner: On the basis of examination and manner stated.	rledge, death oc on and/or invest	curred at the tir gation, in my o	me, date and place, a pinion, death occurre	and due to the called at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	o the o the omple	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Moni	th, Day, Year)

29a. Certifier (Check only one) 29b. Signature and title of certifier

D21244

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. Date filed (Month, Pay Year) 32. Registrar's Signature

State Registrar

		1	For State Registrar		State of	f Marylan		artment of			lental Hyg	giene Reg. No.	005	03503	3
	Physicia	an	1. Decedent's Name (First, Mary Louise								2. Date of Dea Month January		2005	3. Time of Death 3:40 A. M	
	/Medic Examin		4a. Facility Name (If not inst				al:	4b. City, Tow Oak]		of Death			ounty of Death rrett		
	Funeral Director		5. Social Security Number 232-05-5165	6. Se		7. Age (In yrs. 89		tf Under 1 Ye Months Da		r 24 Hrs. Min.	8. Date of Birtl (Month, Day March I	7, Yeer)	9. Birth Cou 915 Ma	place (State or Foreign intry) ryland	
	ō.		Usual Residence of Deceder 10a. State 10b. Co			10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits	_
	the Mar 28e-f sh	Director	MD Ga:	rrett	-	F	riends	ville	le			10g. Citize	n of What Cou	1 X Yes 2 No intry?	_
	3a or	<u>ā</u>	240 Maple S	t.				2	21531				USA		
980	n 72 hours after death with the Maryland "natural", or Items 23a or 28e-f show polical Ever-liner roast be notified at	by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 YDiv] Married	12. Was Dece Armed Fo 1 Tyes If Yes, Giv Year or D	2 X No	i	Was Decedent If Yes, specify 0 1 ☐ Yes 2X			ecify Yes or No- Rican, etc.)		. Race - Amer Black, White pecify: W		
21215-0036		Completed	15. De (Specify only Elementary/Secondary (0		cation de completed) College (1996)	1-4or 5+)	(Give	dent's Usual Oc kind of work do DO NOT use re ol Teach	one during mo tired)	st of work	ing		of Business/l	ndustry	
Maryland 21	be filed stal Hygi ed other event,	Be	17. Father's Name (First, M Charles T.			LS	Belloc	or react	18. Moti		e (First, Middle, riend				_
3	2 should be fi and Mental F is marked of reumatic ever	2	19a. Informant's Name/Rei				19b. Maili	ng Address (Sti			al Route Numbe	r, City or T	own, State, Z	ip Code)	
Ma	s 1 and 2 should f Health and Mer Item 27 is marke other treumatic	n i	John R. Ros											e, MD 21531	L
altimore,	00-		20a. Method of Disposition 1 ☐ Burial 2 💆 Crem 1 ☐ Donation 5 ☐ Ot			Ctata	cemetery, cre	osition (Name of matory or other Side Cr	place)		Date 7, 2005		tion - City or 1 .dsvill		
Balti	permit. Pag Department Important::1 any injury o		21. Signature of Funeral Se	ervice Licens	emai						es, P.A antsvil				
	Physician	2	23a. Part1. Enter the disea shock, or heart failure tmmediate Cause (Final disease or condition resulting in death)	se, or comp List only o	one cause on e	each line.	th. Do not en	ter the mode of	dying, such a	s cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death	
1	/Medical Examiner			ſ	Due to	(or as a consec	quence of):	tia						years	
8760,	ate be executed hysician and the burial-transit	ilcal Examiner	Sequentially list conditions if any, teading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	c	(or as a consec									
.O. Box 68	The law requires that the death certificate be existe has been signed by the attending physician page 2 should be detached for use as the burial	Physician/Med	IF FEMALE: 23b. Was decedent pregnain the past 12 months 1 □ Yes 2 5 No 9 □ Unknown	int	1 Live	tcome of pregn birth 2 Teta nant at time of d	aldeath 3	⊒Ectopic pregn ⊒ Other (specif				23	d. Date of deli Month	very Day Year	
<u>α</u>	 requires that the second of the	b	Part II. Other significent c	onditions o	ontributing to o	leath but not re	sulting in the (underlying caus	e given in Par	t I.	23e. Did t			the cause of death?	1
I Records,		Completed									24a. Was autor perfo 1 ☐ Yes		24b. Were au prior to death? 1 \(\sum \) Yes	topsy findings available completion of cause of 2□ No	,
Vital	cien: ertific ector,	Be	25. Was case referred to n examiner?	nedical	Hospital:	/			Other		th (Check only o				
of	Phys rat di	ion: To	/ -	Pending investigation	28a. Date (Mor		28b. Time of Injury		Injury at Work?	Nursing H □No	ome 5 Resi 28d. Describe		□Other (Spec	ify)	
Division	l or Attending after death. Director: Afte in by the fune	Certification:	3 ☐ Suicide 6 ☐	Could not be determined	e 28e. Plac	e of Injury - At I ling, etc. (Spec	nome, farm, s	treet, factory, of	fice		28f. Location (City or To		Number or Ru	ral Route Number,	_
_	To the Hospitel or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical Co	29a. Certifier Check only one)	ertifying Ph edicel Exam	niner: On the I	e best of my kn basis of examin nner stated.	owledge, dea ation and/or i	th occurred at t nvestigation, in	he time, date my opinion, d	and place eath occu	, and due to the rred at the time,	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)	_
1	To the within 2 To the complet	Me	29b. Signature and title of	certifier	+0	Ka.	_	29c. L	cense numbe				signed (Mont)		
			30. Name and address of	person who	completed cau	ise of death (Ite	m 23a) (Type	Print)	Halin	7.1	Oalla	ud.	Ud 2	1550	_
	St Regist	ate trar	31. Date file (Month, Day		2005	Registrar's Sign	nature	Jules	, igua	7	<u>U</u>	1			

Amend	I.	t¶	m For 5 Cecil Co.	State of Marylar 2/01/05	nd / Depa	artment of H	lealth and Death	Mental I	lygiene	2005	03504
Phys	iciar		1. Decedent's Name (First, Middle, Last)	1				2. Date of Month	Day		3. Time of Death
/Me Exan	dica		Elizabeth Jayne Fl 4a. Facility Name (If not institution, give si			4b. City, Town, or	Location of Dea	Janua		, 2005 County of Death	7:20 P M
LXai		ı	87 Ridge Run Road			North Ea	st		Ce	cil	
Funer Direct			5. Social Security Number 2101-288-2964 1 Usual Residence of Decedent	7. Age (In yrs. 71	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	n. (Month)	Birth Day, Year) 3,19		place (State or Foreign ntry) sylvania
yland		- 1-	10a. State 10b. County	10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
Ba-f s	0		Maryland Cecil	Nor	th Eas						1 Yes 2X No
with the sor 2	2		10e. Street and Number			10f. Zip Code			10g. Cit	izen of What Cou	ntry?
laryland 21215-UU36 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show almantic event, the Maryland Exterior and the redifficial and t		2	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1	1	21901 Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 XNo	ispanic Origin? (n, Mexican, Pue Specify:	(Specify Yes or erto Rican, etc.	No-	ted Stat 14. Race - Ameri Black, White, Specify: Whi	can Indian, etc.
5-C	100		15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	lent's Usual Occupa	ation during most of w	orkina	16b. K	ind of Business/Ir	
Man within	to to la constant	-	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired		J	_	_	
filed v Hygie other i	3	ט	12 17. Father's Name (First, Middle, Last)	2	Opera	tions Man	ager 18. Mother's Na	ame (First, Mic			Service
//an/	9	2	Albert E Theetge				Maria	n Deubl	er		
Maryland 21215-0036 at 2 should be filed within 72 hours at the and Mendal Hygiene. 27 is marked other than "natural", or traumatic event, the Mudical Exercitation.	Ι.		19a. Informant's Name/Relationship (Typ	. ,		ng Address (Street a					
e, N 1 and 1 Health em 27			Harold A Flood/Husb 20a. Method of Disposition			idge Run	Road, No	rth Eas		yland 21 ocation - City or T	
Pages nent of H			1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	11 0 1	cemetery, crer	natory or other place Cremator	y Jan	105 ²⁵ ,		rk, Dela	
Baltimore, Maryla permit. Pages 1 and 2 should Department of Heath and Men Important: If tiem 27 is marke any injury or other traumatic.	once.		21. Signature of Funeral Service License	3		. Name and Addres	ss of Facility C	rouch F			land 21901
Physicia /Medic Examine	al		23a. Part1. Enter the disease, or compile shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the deal e cause on each line. HUPO Due to (or as a consect	th. Do not ent	er the mode of dyin	g, such as cardi	ac or respirator	y arrest,		Approximate Interval Between Onset and Death
cate be executed by sician and the burial-transit		Lyaillie	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	juence of).						
Hecords, P.O. 50X or The law requires that the death certifics ate has been signed by the attending ph page 2 should be detached for use as t	01/40	D -	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown	ic. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	aldeath 3	Ectopic pregnancy Other (specify)				23d. Date of deliv Month	ery Day Year
rdS, P quires that n signed b	1	2	Part II. Other significant conditions conf	ributing to death but not res	sulting in the u	nderlying cause givi	en in Part I.	- 17	id tobacco u		he cause of death?
VItal RECOTGS, sicien: The law requires to certificate has been signe rector, page 2 should be a		andino							utopsy arformed?	prior to co death?	opsy findings available impletion of cause of
f Vital Prysicien: The viscertificate director, pag	ć	מ	25. Was case referred to medical examiner?				26. Place of De			1	
_ × ×	F		27. Manner of Death 1 Natural 5 Pending	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injun Worl	4 LI Nursing	-	esidence be how injur	6 □Other (Speci y occurred	(y)
in Signal		Cel unication.	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci			100 20.00		n (Street an Town, State	d Number or Run)	al Route Number,
To the Hospital within 24 hours a To the Funere! I		edical	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the time vestigation, in my of	ne, date and place pinion, death occ	ce, and due to curred at the tir	the cause(s) ne, date and	and manner as s i place, and due t	stated. o the cause(s)
To the To the Complet			29b. Signature and title of certifier	^		29c. License	a number			te signed (Month,	
			Chem Saygen	MD.		De	05913	1	JA	NUARY,	24, 2005
10			30. Name and address of person who con	,		,		1 0100			
	State	2	Dr. Thomas Duggan 31. Date filed (Month, Day, Year)	32. Registrar's Signa	<u>treet,</u> ature	Elkton,	Marylan	id 2192]			
	istra		JAN 2 6 21	32. Registrar's Signa	A A	corle					

Please Type of	r Print in	Black Inde	elible Ink. E	nsure All C	opies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3 Jime of Death **Physician** Month **GEORGIE JOYCE** GLANDING howar /Medical 4a. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner eston Hospita 10160 Memorial If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) MAY 17, 1926 9. Birthplace (State or Foreign **Funeral** Months Days 1 ☐ M 2 📉 F Hours Yrs. MARYLAND Director 219-74-8380 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28e-f show the Midles Examinar must be notified at 10d. Inside City Limits CENTREVILLE QUEEN ANNE'S Director MD 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21617 USA 601 CHURCH HILL ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A -0--0-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARIE Τ. HUNTER GLANDING ဥ GEORGE L. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 CHURCH HILL ROAD, CENTREVILLE, MD 21617 of Health : EVELYN GREHAWICH/ SISTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 XBurial 2 Cremation 3 Removal from State Department o Importent: if any injury or once. 1-14-2005 CHESTERFIELD CEMETERY CENTREVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, MINIQO rentien 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBRO VASCULAR ACCIDENT **Physician** /Medical Examiner Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician end burial-transit The law requires thet the death certificate be executed Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical as use a IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death P.O. | 5 Other (specify) 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 PNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 Yes 2 No Division of Vital 1 Yes 2 1 No Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After th funeral 27. Manner of Death 28h Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00059487 John Prolses 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219 S. WASHINGTON ST., EASTON, MD 21601 JOHN BOTSIS, M.D., 31. Date filed (Month, Day, Year) 32. Engistrar's Signature State JAN 1 4 2005 Registrar

		•	For Amend Item 23a Registrar	State of Marylan per Dr.,G842	d / Depa , 04/26	artment of H	lealth ar Death	nd Mental Hy	giene Reg. No. 2 0 0 5	03506				
	Physici		Decedent's Name (First, Middle, Last) Blanche I					2. Date of De.		3. Time of Death 12:59 A. M				
Total Control	/Medic Examin	al -	4a. Facility Name (If not institution, give str Southern Maryland Hosp	reet and number)		4b. City, Town, or	Location of		4c. County of De Prince Ge	ath				
	Funeral Director		377-30-0-12-1	7. Age (In yrs.	last birthday) 1 Yrs.	if Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Bin (Month, Da February	y, 17, 1933 W	irthplace (State or Foreign Country) AShington, D.C.				
	Ba-f ehow	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Georg		y, Town or Lo	Oxon F	H11		10g. Citizen of What 0	10d. Inside City Limits 11∰Wes 2 □ No				
	3a or 2	I Dir	10e. Street and Number 2238 Alice Avenue A	pt. #103		10f. Zip Code	20745	i	Ų.Ş.A.	Southly:				
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 is marked other then "natural', or Items 23e or 28e-f ehow important: If item 27 is marked other then "natural per in the Madical Examination and the multiplied at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of H if Yes, specify Cuba 1 Yes 2 No	ispanic Origi In, Mexican, Specify:	n? (Specify Yes or No Puerto Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc. Black				
21215-0036	within 72 hor iene. 'then "netural the Medical E	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12) 12th grade	ation completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired Housewife	ation during most of	of working	16b. Kind of Busines	s/Industry				
Maryland 2	uld be filed Mental Hygi rked other itic event, I	To Be Co	17. Father's Name (First, Middle, Last) Sherman Carte	r				s Name (First, Middle) Bertha Carte						
Mary	d 2 sho th and h 7 is ma trauma			19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (Street and Number or Rural Route Num Yvette M. Wade (Daughter) 20b. Place of Disposition (Name of Date Date										
	es 1 an of Heal f item 2 r other		20a. Method of Disposition 1XXBurial 2 □ Cremation 3 □ Re	20c. Location - City of	or Town, State									
Baltimore,	iit. Pagartment ortant: F injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	res		n Cemetery 2. Name and Addre			5 Clinton, M					
Ba	Depa Impo eny is) Jaret C.	Indees	4	339 Hunt Pl	ace, N.	E. Washingto	uneral Home, n, D.C. 2001	9				
	Physician /Medical Examiner		23a. Part Enter the disease, or complic shock, or heart failure. List only one time tate Cause (Finat disease or condition resulting in death) Sequentially list conditions	Due trior s a crisse	w	Shunt		Shock	rrest,	Approximate Interval Between Onset and Death				
68760,	eath certificate be executed attending physician and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitted events resulting in death) Last d. d.	Due to (or as a consec										
P.O. Box 6	0 0	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregn. 1 Live birth 2 Feta 4 Pregnant at time of c	ıl déath 3[□Ectopic pregnancy □ Other (specify) _	/		23d. Date of d Month	delivery Day Year				
Records,	The law requate has been page 2 should	Completed by PI	Part II. Other significant conditions cont	ributing to death but not res NEXT WOL EXTENTION CO	ulting in the u	angerlying cause give the second cause gives the second cause gives a se	tow o	1 D	Yes 2 No 3	to the cause of death? Probably 4Unknown autopsy findings available o completion of cause of ? es 24XNo				
n of Vital	To the Hospital or Attending Physician: Th within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	To Be	25. Was case referred to menical examiner? 1 Yes 2 1 M6 27. Manner of Death 1 Death 5 Pending	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Resi 28a. Date of Injury (Month. Day Year) 28b. Time of Injury Work? 28c. Injury at Work?						pecify)				
Division	al or Attending s after death. Il Director: Aftendin by the fune	Certification:	2 Accident 3 Suicide 4 Homicide	28e. Place of Injury - At h building, etc. (Speci	ome, farm, st fy)		Yes 2□N		Street and Number or wn, State)	Rural Route Number,				
	e Hospital 24 hours a e Funeral D letely filled i	edical (ician: To the best of my knier: On the basis of examination and manner stated.										
•	To the within 2 To the complete	Mec	29b. Signature and title of certifier	RUM	M	29c. Licens			29d. Date signed (Mo	13/05				
	Je Je		30. Name and address of person who cor	mpleted cause of death (Ite	m 23a) (Type		atts Ro	ad Clinton	Marviand 207	735				
	St	ate	JAN 2 5 2005	Jeon Day 7503 Surratts Road Clinton, Maryland 20735 32. Registrar's Signature										

	1 - For State Registrar	State of	Maryland	-	artment of tificate of		ind Me		iene	15	03507
Physician	Decedent's Name (First, Middentification)	_						Date of Deat	h Day	Year	3. Time of Death
/Medical	GOLDIE	GIBBS	h 1		# at #	. December 2		lanuary	21,2	005	11:15 A M
Examiner	4a. Facility Name (If not instituti DOCTOR S COM		-		4b. City, Town,		Death		4c. Count		ORGE'S
Funeral	5. Social Security Number	+	. Age (In yrs. la	st birthday)	If Under 1 Yea	ır If Under 2	24 Hrs. 8	B. Date of Birth (Month, Day,			place (State or Foreigntry)
Director	053-22-4130	1□M 2፟AF	92	Yrs.	Months Day	s Hours	Min.	January	31	NORT	CH CAROLIN
>	Usual Residence of Decedent 10a. State 10b. Count	hy	10c City	Town or Lo	cotion						10d. Inside City Limits
short and a			roc. Gity,		Cation						1X Yes 2 No
be nutilised be nutilised Director	MD PRINC	E GEORGE'S		BOWIE	10f. Zip Code)		11	Og. Citizen of	What Cou	ntry?
3a or	16010 EXCALE	SUR ROAD			207				U.S.A.		
If item 27 is marked other then "neturel", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	11. Marital Status	12. Was Deced Armed Ford		13.	Was Decedent of f Yes, specify Cu		in? (Speci	ify Yes or No-			can Indian,
F.	1 Never Married 2 Ma	arried 1 Tyes 2	! À No		1 □ Yes 2 🖾 N		, , , , , , , , , , , , , , , , , , , ,	ourr, 610.)	Specia	ck, White, бу: 10 т	ACK
LEX.	3 XWidowed 4 □ Divorce	ed Year or Date	es:								
t, the Madical E Completed	(Specify only high	est grade completed)		(Give	ient's Usual Occ kind of work don DO NOT use retii	e durina most	of working	,	16b. Kind of E	usiness/ir	idustry
marked other then imatic event, Ire M. To Be Comp	Elementary/Secondary (0-12)	College (1-4	4or 5+)	HOME	MAKER				PRIV	ATE	
event, Be C	17. Father's Name (First, Middle	e, Last)			·	18. Mother	r's Name (First, Middle, M	Aaiden Sumai	ne)	
atic e	FRANK PEARSON					ELLA		ALLMA	N		
a ma	19a. Informant's Name/Relation				ng Address (Stree				,		
othar tra	YVONNE CHAPLI	N/GRANDDAUG			DUNWOOI sition (Name of	D VALLE	Y DR		-		20721
or or	1 ⊠Burial 2 ☐ Cremation		tate ce	metery, cren	natory or other p	· ·			20c. Location	•	
in in	* 4 □ Donation 5 □ Other		St.		nels Cem				ueens,		
Important: I any injury o once	K.D.N	omhal	0	74	Name and Add	OVER RO	DAD L	ANDOVER	R, MARY		20785
ician	23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)		ch line.	Do not ent	er the mode of d	ying, such as c	cardiac or i	respiratory arre	est,		Approximate Interval Between Onset and Death DAYS
edical miner			ras a conseque	,	0515 L	EFT I	ÆG				1 WEEK
in and rial-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	Due to (or	r as a conseque	ence of):	onc v			DISEA	SE		DECADES
physician and s the burial-transit dical Examin	resulting in death) Last	1	r as a conseque		LITUS	2					PECA-DES
physicia as the bur edical		d.	D'PIES	7166	- 100,3	-					241720
led by the attending p detached for use as detached for Wee as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 Fetal on that time of dea	death 3	Ectopic pregnan Other (specify)	ncy				ite of deliv	ery Day Year
be d	Part II. Other significant condi	tions contributing to dea	ith but not resul	ting in the ur	nderlying cause g	given in Part I.		23e. Did tob	- 1		he cause of death?
page 2 should be completed								24a. Was ar		Were auto	ppsy findings available
age 2								autopsy perform	ned?	prior to co death? 1 Yes	mpletion of cause of
director, page	25. Was case referred to medic	cal				26. Place	of Death (Check only one		1 1 1 1 1 1 1	2010
this ce al direc	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Min	patient 2 E	R/Outpatien	t 3□ DOA	other: 4 🗆 Nur	sing Home	5 🗆 Reside	nce 6 🗆 Oth	ner (Specia	(y)
	27. Manner of Death 1 Natural 5 □ Pend		Injury , Day Year)	28b. Time of Injury	W	ork?		d. Describe ho	w injury occur	red	
by the f	2 Accident inves	d not be				□Yes 2□N	-	6 Lanation (Ct	and and More		10-11
ed in by the funera	4 Homicide deter	rmined 289. Place of building	g, etc. (S <i>pecify)</i>	ne, rarm, str	eet, factory, offic	θ	20	City or Town		oer or Hura	al Route Number,
Medical Certificat	29a. Certifier 1 Certify (Check only one)	ving Physician: To the base and manner	is of examination	rledge, death on and/or inv	n occurred at the restigation, in my	time, date and opinion, deat	place, an	d due to the ca at the time, da	use(s) and m ate and place,	anner as s and due t	tated. o the cause(s)
de de	29b. Signature and title of certif	1			29c. Lice	nse number		29	d. Date signe	d (Month,	Day, Year)
9		111.			1	1222	VD.		1/2.	1200	2
- G	Veta /	um			L		00		11 41	2Ur	/>
5	30. Name and address of person	on who completed cause	of death (Item	23a) (Type,	Print)_	LLY	00	0 0	1/21		/>
or the compile of the	30. Nam and address of person of the state o	Schinler	of death (Item	KOK	Print) Wee	nway	Ch	Dr. Gr	eenbe	H,M	05 10 20770

Gibbs, Goldic

			1 - For State Registrar	State of Maryla		artment of I <i>rtificate of</i>			giene 2005	03508
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) MAry 4a, Facility Name (If not institution, give s	Gant		4b City Town	or Location of De	2. Date of Dea Month JAn.	th Day Year 15 2005	3:30 A M
U	Funeral Director	ier	Southern Maryland 5. Social Security Number 6. Sex	Hospital	s. last birthday) Yrs.	Clinto: If Under 1 Year Months Days	n	8. Date of Birth	Prince Ge	
	Maryland a-f show lifted at	tor	Usual Residence of Decedent 10a. State 10b. County MD Prince Geo	10c. (City, Town or Lo	cation		Берегот	туто рупс	10d. Inside City Limits MSYes 2 □ No
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic evant, it is Moulcal Examinar must be notified at	Funeral Director	10e. Street and Number 2202 Browns Lane 11. Marital Status	12. Was Decedent Ever in	U.S. 13.	10f. Zip Code 20744 Was Decedent of h	tispanic Origin?	Specify Yes or No-	0g. Citizen of What C USA 14. Race - Am	
-0036	thours after of the sal Examinar	þ	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cub 1 Yes 2 No dent's Usual Occup	an, Mexican, Pue	into Rican, etc.)	Black, Whi	ite, etc. ACk
Maryland 21215-0036	iled within 72 Hygiene. ther then "ne nt, the Medis	Completed	(Specify only highest grade Elementary/Secondary (0-12) 1.2 th. 17. Father's Name (First, Middle, Last)		(Give life.	kind of work done DO NOT use retired	during most of w d)		16b. Kind of Business	
larylano	should be nd Mental marked c	To Be	Eunice Carter 19a. Informant's Name/Relationship (Type				Annie		; City or Town, State,	
Baltimore, N	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other trae		Brenda C. Mason/Ni 20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	20b.	Place of Dispo	osition (Name of matory or other place	08)	Date	con, MD 207 20c. Location - City or crentwood,	Town, State
Balti	permit. Departr Importe any inju		21. Signature of Funeral Service License	hall	42	Name and Addre	ss of Facility MA St. N.W.	rshall's Washingt	Funeral Ho on, D.C. 2	ome 20011
1	Physician /Medical Examiner		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse		A	ig, such as cardi	ac or respiratory are		Approximate Interval Between Onset and Death
8760,	death certificate be executed to attending physician and of for use as the buriat-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a conse	quenca (if):	,,,				
O. Box 68	at the death certifics by the attending pt lached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fer 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
Records, P	The law requires that tte has been signed b page 2 should be deta	Ď	Part II. Other significant conditions cont	tributing to death but not re	sulting in the ur	nderlying cause giv	en in Part I.		eacco use contribute to	
		e Completed	25. Was case referred to medical				26 Place of De		prior to death? No 1 Yes	utopsy findings available completion of cause of
ō	or Attending Physician: frer death. Director: After this certific in by the funeral director.	ation; To B	examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	er: 4 ☐ Nursing	eath (Check only one Home 5 Reside 28d. Describe ho	nce 6 □Other (Spe	cify)
	- 4	al Certification;	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Specician: To the best of my kn	ify)		ne date and plac	City or Town		
Allen . T	To the Hospite within 24 hours To the Funeral completely filler	Medical	(Check only 2 Medical Examine 29b. Signature and title of synthes	ician: To the best of my kner: On the basis of examin and manner stated.	ation and/or inv	29c. License	number	29	d. Date signed (Month	h, Day, Year)
2	Sta Registr		30. Name and address of person who com NENEAT S. Ama 31. Date filed (Month, Day, Year) IAN 25 2005		1 Sur	Print) 2A775 /	long 1	4307 C	1/17/20 unton	m) 20735

ORIGINAL

		For State Registrar	State of	Maryland / De _l	oartmer e <i>rtificat</i>					giene	11115	03509
Physic /Medi		Decedent's Name (First, Middle, I PHYLLIS	GRAH	AM					2. Date of Dea Month	Day	Year 2005	3. Time of Death - 1:35 PM
Exami		4a. Facility Name (If not institution, g	AL		LANE	IAM	Location of	of Death		4c.	County of Deat	h
Funeral Director		5. Social Security Number 6 064-48-9361 Usual Residence of Decedent	. Sex 7. 1 □ M 2 ☑ F	Age (<i>In yrs. last birthda</i> 47 Yrs.	y) If Under Months		Hours	Min	B. Date of Birth (Month, Day May 11	/. Yearl	Co	hplace (State or Foreign ountry) inia
death with the Maryland rms 23a or 28a-f show could be muffind at	Director		GEORGE'S	10c. City, Town or UPPER M	ARLBOI							10d. Inside City Limits 1X Yes 2 □ No
ath with th	ral Dire	10e. Street and Number 10137 SCOTCH HI	LL DRIVE		10f. Zip	Code 20774	+				zen of What Co	ountry?
P 2 3	by Funeral	11. Marital Status 1 □ Never Married 2 🖾 Married 3 □ Widowed 4 □ Divorced	12. Was Decedor Armed Forc 1	es?	3. Was Deced If Yes, spe 1 Tyes	cify Cuba	ispanic Origin, Mexican Specify:	gin? (Spec n, Puerto Ri	ify Yes or No- ican, etc.)		14. Race - Ame Black, White Specify:	
Maryland 21215-0036 d 2 should be filed within 72 hours after th and Mental Hygiene. It is marked other than "natural", or Its traumatic event, the Medical Equiption	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) College (1-4	lor 5+)	edent's Usur ve kind of wo DO NOT us Postal	rk done d se retired	during most ()	t of working	:		nd of Business/	Industry
Maryland 2121 12 should be filed within 1 and Mental Hyglene. 7 is marked other than "	To Be Co	17. Father's Name (First, Middle, La LITTLETON WILLIA			roscar				First, Middle,			
e, Mary I and 2 sho Health and I om 27 Is mu		19a. Informant's Name/Relationship LESLIE GRAHAM/HU		1013	7 SCOI	CH H		ORIVE	UPPER	MARI		ARYLAND 2077
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any july or other traumatic evonce.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Special Service Lie	oify)	Resurrec	tion (22. Name ar	Ceme to Address	ery]	J. E	05 (3. JENK	CLIN'	Cation - City or TON, MAR FUNERAL	YLAND L HOME
Physician /Medical Examiner	dical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate the constant of the constant	a. 20 Due to (or Due to (or	sed the death. Do not e		e of dying					RYLAND	Approximate Interval Between Onset and Death MI, NUKS YEWS
.O. Box (the death certify the attending y the attending	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ☐ Fetal death 3 it at time of death 5	□Ectopic pr					2	3d. Date of deli	very Day Year
cords, P		Part II. Other significant conditions	contributing to deat	th but not resulting in the	underlying c	ause give	on in Part I.	_	23e. Did tob		e contribute to	the cause of death?
I Rec The law ate has b	Completed								24a. Was a autops perform	y	24b. Were aut prior to c death? 1 \(\text{Yes}	opsy findings available ompletion of cause of
on of ding Phys	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigati 2 Accident investigati 3 Suicide 6 Could not	on be 280 Disease	-	of 2	8c. Injury Work 1 🗆 Y	ır: 4 □ Nur	rsing Home 280	d. Describe ho	ence 6 ow injury		ify) ral Route Number.
Divisit To the Hospital or Attantwithin 24 hours after dealt To the Funeral Diractor: completely filled in by the	ledical Certif	4 Homicide determine 29a. Certifier 1 Certifying F	building	est of my knowledge, deas of examination and/or	ath occurred	at the tim	e, date and	t place, and	City or Town	, State)	and manner as	stated
To the H within 24 To the F complete	Medi	29b. Signature and title of certifier Advenue	Rerus	stated.	290	. License	number		25	9d. Date	signed (Month	, Day, Year)
D 0		30. Name and address of person wh	N. M. D.	575 MA11	o, Print)	5017	E 35	7 4	AUREL	pl	0 20	707
Sta Regist	_	JAN 2 5 2005		istrar's Signature								

		i icasc	State of Man			of Health and	Mental Hygien	e) 0 0 c	0000
		1 - For State Registrar	J			of Death	Reg. N	E- U U U	03510
		Decedent's Name (First, Middle, Last	0	· · · · · · · · · · · · · · · · · · ·			2. Date of Death	ay Year	3. Time of Death
Physic /Med		Ruth		Green			January J	2005	2:50 P ^M
Exam		4a. Facility Name (If not institution, give	street and number)		4b. City, To	wn, or Location of Deat		c. County of Death	n
		Holy Cross Nursi		a com la se biodo da	Burt If Under 1	onsville Year If Under 24 Hrs	O Date of Birth	Montgon	nery
Funera Directo		5. Social Security Number 6. Se 190–26–6913	7	n yrs. last birthda) OYrs.	Months [Days Hours Min.		1914 Peni	nplace (State or Foreign untry) nsylvania
		Usual Residence of Decedent							
ryland		10a. State 10b. County	10	Dc. City, Town or					10d. Inside City Limits
se Ma	octo	Maryland Montgomer	У	Burton					1 ☐ Yes 2√2 No
with the	<u>a</u>	10e. Street and Number			10f. Zip C		10g. C	Citizen of What Co	untry?
eath	Funeral	3415 Greencast1	12. Was Decedent Eve	er in U.S.		866 nt of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No-	U.S.A. 14. Race - Amer	ncan Indian,
or iter	Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 24 No				to Rican, etc.)	Black, White	e, etc.
IIIG X IX I 3-0030 be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23e or 28e-f show event. I've Medical Evarifies must be notified at	Completed by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 Yes 2	No Specify:		Specify:	
72 h	lete	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Gi	cedent's Usual (ive kind of work of DO NOT use	done during most of wo	rking 16b.	Kind of Business/I	ndustry
within ene.	E C	Elementary/Secondary (0-12)	College (1-4or 5+)	""6				Domosti	
filed Hygin	ပိ	12 17. Father's Name (First, Middle, Last)			Homem		me (First, Middle, Maide	Domestic en Sumame)	
land lid be fils fental Hy rked oth	To B	Marshall Green				Sar	ah Moss		
partimore, Marylatin 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23e or 28e-1 show any injury or other traumatic event, the Madical Examiner must be notified at		19a. Informant's Name/Relationship (7	ype, Print)				ural Route Number, City		îp Code)
and and man an		Terrance S. Green/					er Spring, N		
DallIMOTE, Sermit. Pages 1 a Department of Her mportant: if item any injury or othe		20a. Method of Disposition 1 Durial 2 Cremation 3 D	Hemovai irom State	20b. Place of Dis cemetery, c				Location - City or 1	
it. Pa		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License		Fort_Lin	coln Cr	ematory 1/4	4/2005 Brei	itwood, N	1D
Depa Depa impo any i	BOUG	21. Signature of Political Solvice Literature	100				nes-Rinald Te Ave. Silv		ng, MD 20904
		23a. Pari 1. Enter the diseas or comp	olications that caused the					/CI bpili	Approximate
Physician		shock, or heart failure. List only of Immediate Cause (Final	Dementia						Interval Between Onset and Death
/Medica	1	disease or condition resulting in death)	Due to (or as a co						
Examine	. .	Sequentially list conditions,	b						
ed sit	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Irijury	Due to (or as a co	onsequence of):					
ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a co	onsequence of):					
te be e ysician ne buria	caiE		d						
tific ng pl									
ath cer attendir for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 Live birth 2 □	Fetal death	3 □Ectopic preg	gnancy	1	23d. Date of deli-	very Day Year
• 0 0 9	sici	1 Yes 2 No 9 Unknown	4∏Pregnant at tim 9☐ Unknown	ne of death	5 ☐ Other (spec	city)		Month	Suy
ords, F.C requires that the een signed by th hould be detache	P.	Part II. Other significant conditions co	ontributing to death but n	not resulting in the	e underlying cau	se given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ds, uires sign	d by						1 🗆 Yes	2√2 No 3 □ Pro	obably 4 Unknown
iaw requas been 2 shoul	ompieted						24a. Was an	24b. Were au	topsy findings available
age h	duo						autopsy performed? 1 ☐ Yes 2 € 2 € 2 € 2 € 2 € 2 € 2 € 2 € 2 € 2	prior to c death? 1 \(\sum Yes\)	ompletion of cause of
VICAL ilcian: T certificat rector, p	BeC	25. Was case referred to medical examiner?				26. Place of De	ath (Check only one)	0 1 1 1 1 1 1	
- CO CO CO	To E	1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatient	2 ER/Outpat			Home 5 Residence		rify)
On On ding Phy th. After thi funeral	lon	27. Manner of Death 1 XNatural 5 Pending	28a. Date of Injury (Month, Day Ye	(ear) 28b. Time Injur	У	c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inj	ury occurred	
VISION Attending or death. ector: Afte	ertification;	2 Accident investigation 3 Suicide 6 Could not be		- At home, farm.	M street factory of		28f. Location (Street a	and Number or Ru	ra I Route Number.
- 5 2 E C	ertii	4 Homicide determined	building, etc. (S	Specify)	2201, 14.01019;	55	City or Town, Sta		
spit ours	ledical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exem	ysician: To the best of m	amination and/or					
Fo the Hos vithin 24 h Fo the Fur completely	Med	29b. Signature and title of certifier	and manner stated		29c. l	License number	29d. D	ate signed (Month	, Day, Year)
- 3-) faul 1006		6		D / 2 2 2 7	т _	10	2004
5	and the same of	30. Name and address of person who			oe, Print)	D43237		ıary 10,	ZUU4
			11			uite 102 La	urel, MD 20)707	
Regis	State strar	31. Date filed (Month, Day, Year)	32 degistrar's	Signature	parte				

			1 - For State Registrar	State of Marylar	nd / Dep		t of H	lealth a				ans	03	511
	Physic	ian	Decedent's Name (First, Middle, Las	1)						2. Date of Dea Month	ath Day	Year	3. Time	of Death
No.	/Medi			h M. Gunther						January	18	2005		0 A M
	Exami	ner	4a. Facility Name (If not institution, give	street and number)				Location of	of Death			ounty of Dea	th	
			5222 Hermit Path 5. Social Security Number 6. Se	x 7. Age (In yrs.	last hirthday	If Under	olum 1 Year	bia If Under 2	24 Hrs	9 Date of Bid		loward	th (Oth-	C
н	Funeral Director		·	M 2 DXF 91	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day	y, Year)			e or Foreign
66	The same of the sa		Usuat Residence of Decedent	71						Apr 2,	1913	Mas	ssachu	setts
	thow	_	10a. State 10b. County	10c. Cit	y, Town or Lo	ocation								City Limits
	Ba-f s	cto	MD Howard	Je	essup								1 🗆 Y	es 2 No
	vith th	Funeral Director	10e. Street and Number			10f. Zip					10g. Citize	on of What Co	untry?	
	s 236	era E	8339 Peachwood	10 Mac Decedest Free is 11	C 10		2079		1.0.10	7 11		ted St		
	Item Item	Ę	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 🖾 No	.S. 13.	Was Deced If Yes, spec	ent of H	ispanic Orig in, Mexican,	, Puerto	cify Yes or No- Rican, etc.)	14	Race - Ame Black, Whit	ncan Indian. e, etc.	,
36	urs af	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	2⊠ No	Specify:			S	pecify:	hite	
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28a-f show ha Madical Exeminar must be notified at	Completed	15. Decedent's Edu		16a. Dece	dent's Usua	Occupa	ation			16b. Kind	of Business/		
215	thin 7	ple	(Specify only highest grad	College (1-4or 5+)	(Give life.	kind of wor DO NOT us	k done d e retired	during most ()	of worki	ng	John	s Hopk	ins	
2	filed with Hygiene other the	S	Elementary/Secondary (0-12)		Food	Servi	.ce 1	Manage	er		Appl	ied Ph	ysics	Lab
pu	tal High	Be	17. Father's Name (First, Middle, Last)					18. Mother	r's Name	(First, Middle,	Maiden St	umame)		
Z	should be ind Mental i marked o umatic eve	ို	Frank Fellows							ttinghar				
Maryland	C1 00 = 00		19a. Informant's Name/Relationship (T)							Route Numbe		own, State, 2	(ip Code	
	1 and Health em 27		Brenda Lee Hager/I 20a. Method of Disposition		Place of Dispo		10000	Jess		MD 2079		tion - City or	Tour State	
Baltimore,	0 0		1 Burial 2 □Cremation 3 □F	Removal from State	emetery, crer	natory or ot	her plac					•		
Ħ	글로만큼.	1	 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 	Cr	rest La	wn Me	m. C	ard.	1-2	L-2005	Marr	iottsv	ille,	MD
Ba	Depa Impo eny i		1 St. C.DO	M01044	1	112	12 0		Harı	y H. Wi	Ltzke	's Fam	ily Fi	I Inc.
			23a. Part1. Enter the disease, or comp	lications that caused the death						Pike Ell		t City	Approxim	
	Physician		Immediate Cause (Final	ne cause on each/line.								Onset an	elween	
	/Medical		disease or condition resulting in death)	Alzheimer's Due to (or as a consequence)		ise							2 yea	ers
	Examiner				201100 01.7.									
		ner	Sequentially list conditions, if any, leading to ammediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ	uones of):									
	ate be executed hysician and the burial-transit	Examiner	that initiated events	c										
,092	e exe		resulting in death) Last	Due to (or as a consequ	uence of);									
876	death certificate be executed e attending physician and d for use as the burial-transit	lical		d										44.54
x 68	eath certifica attending ph for use as th	Physician/Med	tF FEMALE:			- 40	(CI)		- 100				-210	
Вох	ath c	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pre					230	 Date of delified the second of the second of	very Day	Year
	at the de by the a tached	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5	Other (spe	cify)						52,	
۳.	£ 8 €		Part II. Other significant conditions con	ntributing to death but not resu	ulting in the u	nderiving ca	use dive	n in Part I.		23e. Did toi	bacco use	contribute to	the cause o	f death?
ds	uires sign ld be	d by			J	, ,	•				es 2 🗆		bably 4 [
Ö	w requir been si should	Completed								24a. Was a		145 18/22 211		
Re	The lay	Ĕ							_	autops	y	24b. Were aut prior to c death?	ompletion of	cause of
tal		ပို	25. Was case referred to medical					00 81	- (D).		No No	1 🗆 Yes	2 ∑ No	
of Vital Records,	Physician: this certific at director,	0 0	examiner?	Hospital: 1 Inpatient 2	ER/Outpatien	t 3 🗆 DOA	Othe			(Check only on		30sh == (0===	4.1.7774014	n hama
		E	27. Manner of Death	28a. Date of Injury	28b. Time of		c. Injury	at	-	8d. Describe ho		Other (Spec	m) grou	o nome
Ö	Attending I r death. ector: After by the funer	atlo	1X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	м	Work 1 □ Y	? ′es 2 □ Ni	o					
Division	I or Attendate death Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory,	office		2	8f. Location (St. City or Town	reet and N	lumber or Rui	ral Route Nu	mber,
	ital or A	Cer		, , , , , , , , , , , , , , , , , , , ,	<u> </u>				Į.	ony or rown	, 5(2(6)			
	ne Hospital or a no 24 hours after on 24 hours after on Funeral Direct of the property filled in the property filled in the property filled in the property filled in the property of the prop	edical	(Check only 2 Medical Exemi	sician: To the best of my knowner: On the basis of examinat	wledge, death	occurred a	t the time	e, date and inion, death	place, a	nd due to the ca	ause(s) an	d manner as	stated.	(s)
	# # # # # # # # # # # # # # # # # # #	Med	29b. Signature and title of certifier	and manner stated.										(3)
	S T N		Signature and title of certifier				License					igned (Month		
			74				0353	09			Janua	ry 19,	2005	
00			30. Name and address of person who co					a'.		01015				
	Sta	te	Sandra Sattin, MD 31. Date filed (Month, Day, Year)	2850 N. Ridge 32. Agistrar's Signat		ETTICO	ott (City,	MD_	21043				
	Registr		JAN 2 5 20											

				Otato of Ma	i yiai ia		cate of	Death		Reg. No. 2 ()	05	03	512
	Physicia		Decedent's Name (First, Middle, Last Laverne Clement		າກ				2. Date of De Month Januar	Day	Year	3. Time o	
7	/Medica		4a Fecility Name (If not institution, give		ш	_		4b. City, Town, or L	1			7,50	CZ/17
1	Examine	r	100 Honeysuckle I		107			Frostbur	g	Alleg	gany		
	Funeral Director		220 02 1.71	ex □ M 2√2 F 69	(In yrs. las		Under 1 Yea onths Days		(Month, Da	th ly, Year) 4, 1935	Countr	Land	or Foreign
and	ž.,,	- 1-	Usuel Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location	n				10	d. Inside C	ity Limits
Meryl	tied a	ğ	MD. Allegany	7	Fro	stburg						XXYes	2 □ No
th with the	23e or 28	runeral Director	10e. Street and Number 100 Honeysuckle I	Lane, Apt.	107		of. Zip Code 2153			10g. Citizen of V United	State	s	
21215-0020 within 72 hours efter deeth with the Meryland		2	11. Marital Status 1 Never Married 2 Married 3XXVidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 22000 If Yes, Give Year or Dates:			Decedent of s, specify Cu Yes 2/1/2/No	Hispanic Origin? (S ban, Mexican, Puert o Specify:	pecify Yes or No o Rican, etc.)	Specify	e - America ck, White, e White	tc.	
22 hg	dical	lo be completed	15. Decedent's Ed (Specify only highest gra	ucation de <i>completed)</i>		16a. Decedent (Give kind	s Usual Occi	upation e during most of wor ed)	king	16b. Kind of B		ustry	
12 a	then.	Ĕ	Elementary/Secondary (0-12) Unknown	College (1-4or 5-	+)		emaker			House	ework		
ם שון	other of	္ ဗ	17. Fether's Neme (First, Middle, Last)					18. Mother's Nan				-	
Vid bi	mrked affc e	0	Dewey C.	Llewelly	yn			Nell		oadwater			
Maryland	treum treum		19a. Informant's Name/Relationship (7 Doretha Robertson		_	7		et and Number or Ru k Hollow					532
Baltimore, I	if item 27 or other	-	20a. Method of Disposition 1 ☐ Burial 2, ☐ Cremation 3 ☐	Removal from State	20b. Pla	ce of Disposition netery, cremeto berland	n (Name of ny or other pi	ace)	Date 01/27/	20c. Location - Cumberl	City or Tow	vn, State	 Land
# # #	ortant: Injury	-	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		7			ress of Facility Bo	2005	ral Home			
B E	o de la companya de l		7 Ways	Bal		111	Churc	h St., We	sternpo:	rt, Mary	land	2156	
) /N	ysician ledical leural transit	xaminer	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate	b	Oue to (or e	sclero	ce of):	ith med:	ical co	omplica	ation		yrs
, Box 68760, deeth certificate be executed	Çı w .		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Oue to (or a	s a consequen	>e of):						
Box	d for u		Pert II. Other significant conditions of	ontributing to death bu	t not result	ing in the under	lying cause (given in Part I.	23b. Did	tobacco use co	ntribute to	the cause	of death?
P.O.	d by the	٦							1 🗆	Yes 2□ No	3 🗆 Probe	ably 'X	Unknown
ords,	speen s	Completed by								an eutopsy ormed?	avai	re autopsy ilable prior ipletion of eeth?	to
I Rec	ege 2	E							10	Yes 2 No		Yes 2] No
	ctor, p		25. Was case referred to medical examiner?					26. Plece of Dea	ath (Check only	оле)			
of Vita Physician:	this ce	2	1)X Yes 2□ No				D DOA	-		dence 6 □Oth)	
O Billing	After 1		27. Manner of Death Naturel 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Dey		28b. Time of Injury	28c. In W	ork? ☐ Yes 2 ☐ No	200. Describe	now injury occur	100		
Division	within 24 nours ared beeth. To the Funerel Director: After this certificate has completely filled in by the funerel director, page 2	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined			ne, farm, street,	factory, offic	9		Street and Numi wn, Stete)	ber or Rural	Route Nur	nber,
Hospita	within 24 hours a To the Funerel D completely filled	edical	29a. Certifier (Check only one)	ysician: To the best of	examinatio	edge, death oc on end/or invest	curred at the gation, in my	time, date end place opinion, death occu	, and due to the pred at the time,	cause(s) and m date and place,	anner es sta and due to	ated. the cause((s)
o the	o the	8 Σ	29b. Signeture and title of certifier/	and mariner stat	ieu.		29c. Lice	nse number		29d. Date signe	ed (Month, D	Day, Yeer)	
ř	≶ ⊢ ō		1 (Xas	how	1257		Do9	157		Jan 2	7 200	5	
		-	30. Name end address of person who	completed cause of de	eath (Item 2	23a) (Type, Prin	t)	Narral and	21502	· · · · · · · · · · · · · · · · · · ·			
			Dr. Paul Snow, 1	24 W. 3rd	St.,	Cumber.	Land'	ar Argud					
	State	е	31. Date filed (Month, Day Year) 2	8 2005 Registr	n s signatu	Mr.	1. 19						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JAN 2005 **Physician** 23 05:02A Lawrence Howard Greene /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CIVISTA MEDICAL CENTER LAPLATA CHARLES If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Director 63 12/13/1941 186-36-4813 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Items 23a or 28a-1 show the Medical Examiner must be notified at 1 ₹ Yes 2 No Director MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? C Heron Place 20603 Funeral 11212 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Research Chemist Manufacturing injury or other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other trainmasts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Henry Greene Virginia Capito 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Greene/Son 11212 C Heron Place, Waldorf, MD 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ∑Buriai 2 ☐ Cremation 3 ∑Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Oakwood Cemetery 1/26/2005 Sharon, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Raymond-Wood Funeral Home 0 PO Box 430, Dunkirk, MD 20754 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IRRHOSIS LIVER **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dua to for as a consequence off The law requires that the death certificate be executed Due to (or as a consequence of): as the burialattending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 | Fetal death in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 2□ No 1 Yes 2 ₽ No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1∠Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1. Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

the

Division of Vital Records, P.O. Box 68760,

21215-0036

Baltimore, Maryland

CRACE

RENG

State Registrar

31. Date filed (Month, Day, Year)

MATHUR, NALIN,

29b. Signature and title of certifier

JAN 2 5 2005 N

32. Registres Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MATHUR, NALIN, MD 10 ST PATRICK DRIVE SUITE 404 WALDORF MD 20603

29c. License number D = 5 2 2 8 9

29d. Date signed (Month, Day, Year)

123/05

State Registrar THE WORK NICHARG

31. Date filed (Month, Day, Year)

32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

readin

32. Registrar's Signature

O.C.M.E.

JANUARY 25,2005

111 PENN STREET BALTIMORE, MARYLAND 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#20b, perHI, C840, 2/14/05 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 24, January 2005 11:15a Amalia "Oma" Herring /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Elkton 1080 Warburton Rd. Ceci1 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | June 5, 1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√2 F 84 Yrs. 218-40-0295 Austria Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Marylan Hygiens other than "natural; or Items 23a or 28a-1 show ent, I'm Madical Esaminat must be multified at 1 ☐ Yes 2 X No MD Ceci1 Directo E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21921 1080 Warburton Rd. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White ģ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Household permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Important: If item 27 is marked other It any injury or other traumatic event. Its
once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Andrew Roidmayr Anna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Susan Herring/Daughter 1080 Warburton Rd., Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan Date 26 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Arlington, VA * 4 ☐ Donation 5 ☐ Other (Specify) Arlington National 2005 Cemeter 3. Name and Address of Facility 21. Signature of Funeral Service Ligensee Andrew G. Gee Funeral Home / Reder 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Kton, shock, or heart failure. List only one cause on each line. Muare Appr t-Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HupexIA Physician /Medical Due to (or as a consequence of): Examiner UNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Que to for as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 20 No
9 Unknown Year Month Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ ANGER 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 Z{No Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JANUARY, 25, 2005 Do05 9131 regger Glon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 207 NORTH STREET BLITTON MD DUEGAN, M. O. Thomas 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 5 2005 Registrar

			For State	State of Man			Health and	Mental Hyg		e.
			Registrar 1. Decedent's Name (First, Middle, Last)		Timeate of	Dealii	2. Date of Dea	- MI	3. Time of Death
	Physic		Mill	icent J. Ho	rton			Januar		ear
	/Medi Exami		4a. Fecility Name (If not institution, give			4b. City, Town,	or Location of Dea		4c. County of	70
			Millennium Nursing	y Home		Ellico	tt City		HOW	vard
	Funeral		5. Social Security Number 6. Se	7 57	n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year	Birthplece (State or Foreign Country) Onio
1	Director		277 28 2975 Usual Residence of Decedent	JM 2LXF 73	Yrs.			Jan 20,	. 1932	Ohio
	/land		10a. State 10b. County	10	Oc. City, Town or Lo	ocation				10d. Inside City Limits
	Man B-fath	to	MD Howard		Elkridge	2				1 ☐ Yes 2 No
	th the	lre	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	at Country?
	be filed within 72 hours after death with the Maryland nat Hygiene. ed other than "natural", or Itams 23a or 28a-f ahow event, the Medical Examities must be notified at	Funeral Director	6636 Washington Bo			2107	75		United	l States
	er deg	nue	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of If Yes, specify Cut	Hispanic Origin? (Span, Mexican, Pue	Specify Yes or No- to Rican, etc.)		American Indian, White, etc.
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	White
8	2 hou	ed	15. Decedent's Edu		16a, Dece	dent's Usual Occu	pation		16b. Kind of Busin	
215	hin 72 an "na Media	plet	(Specify only highest grad	College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wo	orking	Too. Tand or Doom	iosa ii dusti y
21	filed with Hygiene. ther ther	Completed	12		Assi	.stant Ma	nager		Giant F	'cood
P	d oth	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, I		
Z	2 should be filed withir and Mental Hygiene. Is marked other than sumatic event, Lie M.	2	Wilbert E. Lowe					izabeth M		
Maryland 21215-0036	d 2 st h and 7 le n traun		19a. Informant's Name/Relationship (Ty Vicki Booth/Daught					ural Route Number OCKPOPT,		
	is 1 and 2 should of Health and Mer Item 27 is marks other traumatic		20a. Method of Disposition		20b. Place of Dispo cemetery, crei				20c. Location - Cit	
Baltimore,	9° = 5		Magazial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)		cemetery, cres Crest Law					sville, MD
Ħ	그는 근 중 .		21. Signature of Funeral Service Licens			_		The second secon		amily FH Inc.
ä	Deparent Dep		Jun Collins	athe						y, MD 21043
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	ications that caused the ne cause on each line. a. END ST. Due to (or as a co	AGE onsequence of): HOL			c or respiratory arm		Approximate Interval Between Onset and Death
68760,	rificate be executed og physician and as the burial-transit	fedical Examiner	f any, leading to amediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):				le .	
P.O. Box	requires that the death certificat wen signed by the affending phy hould be defached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 XNo 9 □ Unknown	3c. If yes, outcome of p 1□Live birth 2 □ 4□Pregnant at time 9□ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	f delivery Day Year
	es thaf igned b be defa	by Pt	Part II. Other significant conditions cor	ntributing to death but no	ot resulting in the u	nderlying cause giv	ven in Part I.	23a. Did tob	acco use contribu	te to the cause of death?
ğ	w require been sig should b							1 □ Ye	s 2 No 3	Probably 4 2 Unknown
Vital Records,	aw Ist 2 s	ompleted						24a. Was ar		autopsy findings available
æ	The law ate has b page 2 s	Com						autops perform	ned? deat	to completion of cause of h? Yes 2☑No
/ita	ilclan: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only one		
-	Physician: rthis certificatal director, I	ပ္	1 ☐ Yes 2 ☑ No	lospital: 1 Inpatient	2 ER/Outpatien	1 3LI DOA		lome 5 ☐ Reside	nce 6 Other (Specify)
Ü.	ling P	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Injui Wo		28d. Describe ho	w injury occurred	
Division of	Attending r death. ector: Affer by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	At home form etc		Yes 2 □ No	296 Leastine (Ct		2 12 11 11
O	To the Hospital or Attending I within 24 hours affer death. To the Funeral Director: Affer completely filled in by the funer	Certification:	4 Homicide determined 29a. Certifier 125 Certifying Physics	building, etc. (S	Specify)	•		City or Town	, State)	r Rural Route Number,
	e Hos 24 hc e Fun letely	edical	(Check only one)	sician: To the best of more: On the basis of exa and manner stated.	amination and/or inv	estigation, in my c	me, date and place opinion, death occu	s, and due to the ca scred at the time, da	use(s) and manne ite and place, and	r as stated. due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	2		29c. Licens			d. Date signed (M	lonth, Day, Year)
				PRIMAR 7	CARE	DOG	55694	8]	anuary 2	4, 2005
23	—		30. Name and address of person who co			Print)	. 0.1			MORE MD
			JANES IAN. 31. Date filed (Month, Day, Year)			22 Di	D LIVHIN	311456	1 (5170)	II WE MY
	Sta Registr			32. Registrar's	Signature	and .				

			1 - State State Registrer	of Maryland / Dep Ce	partment of Fertificate of			A see	The grown
			Decedent's Name (First, Middle, Last)			-	2. Date of Dea	L /	Sting outeath 7
	Physici /Medio		WILLIAM E. HANDY				Month	1 81 2	005 10:20AM
	Examir	ier	4a. Facility Name (If not institution, give street and no	ımber)	4b. City, Town, o		Death	4c. County o	
	Funeral		WILLIAM HILL MANOR 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	EAST				BOT 9. Birthplace (State or Foreign
	Director		043-22-1746 1XM 2□F	76 Yrs.	Months Days	Hours	Min. (Month, Day MARCH 10	0 1928	MINNESOTA
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	ocation				10d. Inside City Limits
	Marylan -f show lled at	Ď	MD TALBOT	EASTO					1 ☐ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number	LASIC	10f. Zip Code		1	0g. Citizen of Wi	Λ
	23a c	alD	545 CYNWOOD DRIVE		216	01		U	ISA
	er deg	by Funeral	Armed F	cedent Ever in U.S. 13 orces?	. Was Decedent of H If Yes, specify Cub	lispanic Origi an, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)		- American Indian, , White, etc.
036	urs aff	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes G 3 ☐ Widowed 4 ☐ Divorced Year or I	2 No ive Dates:	1 ☐ Yes XX No	Specify:		Specify:	WHITE
2	within /2 hours atler death with the Maryland ene. Then "natural", or Itams 23a or 28a-f show the Medical Examinar must be multified at	Completed	15. Decedent's Education (Specify only highest grade completed	16a. Dec	edent's Usual Occup e kind of work done	ation	of working	16b. Kind of Bus	iness/Industry
12	Mithin than	mple			DO NOT use retired OWNER	d)	, noming	DDTMTTM	G COMPANY
0	Hygie Hygie Sthar I	မ င်	17. Father's Name (First, Middle, Last)		OWNER	18. Mother	s Name (First, Middle, I		
Maryland 21215-0036	should be filed within 72 hours after death with the Maryla nd Mental Hygiene in marked other than "natural", or Itams 23a or 28a-1 shov marked other than "natural", or Itams 23a or 28a-1 shov imetic avant, the Medical Exambre in ust be notified at	To B	ERASTUS EDWARD HANDY				COSLETT		
lar,	A 60 60		19a. Informant's Name/Relationship (Type, Print)				or Rural Route Number		
σ.	ges 1 and 2 tof Health If itam 27 or othar tr	1 3	SUSAN H. duPONT/DAUGHTE 20a. Method of Disposition	R 580		RS RES	ST CIRCLE, I	•	MD 216U1 City or Town, State
altimore,	permit. Pages Department of H Important: If its any injury or of once.		1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State cemetery, cri	ematory or other place	· 1			
alt:	partmi portar y injur		21. Signature of Funeral Service Licensee	/)	22. Name and Addre	ss of Facility	TR 1/22/2005		
<u> </u>	88 18 8	4 1	JOHN R. MERO	ERON 2	ELLOWS, H OO S. HAR	ELFENE RISON	BEIN & NEWNA ST EASTON,	M FUNER MD 2160	AL HOME PA
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do not eleach line.	nter the mode of dyir	ng, such as ca	ardiac or respiratory arre	est,	Approximate Interval Between Onset and Death
5	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	A					Oriset and Death
	xaminer		C	(or as a consequence of):	J. T.	alee	,		200
	D =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(or as a consequence of):	- Cocco.		024		270
	and -trans	Examiner	that initiated events	(or as a consequence of):					
8760,	cate be executed obysician and the burial-transit	dical E		(or do a consequence or).					1
68	cernicate be executed ding physician and ise as the burial-transit	a)	U						
Вох	e attending p	Physician/M	in the past 12 months?		□Ectopic pregnancy	,		23d. Date	,
0	0 0	yslc	1 ☐ Yes 2 ☐ No 4 ☐ Preg 9 ☐ Unknown 9 ☐ Unkr		Other (specify) _			, inches	Day Teal
S, D	ine law requires trat the las been signed by thoage 2 should be detached.	by Ph	Part II. Other significant conditions contributing to o	leath but not resulting in the	underlying cause giv	en in Part I.	23e. Did tob	pacco use contrib	oute to the cause of death?
ords	s been signed to should be detailed.	ed b	e Meledas Q	lliter -	uncant	voled	1 🗆 Ye	s 210 No 3	Probably 4 Unknown
ecord	as be	Completed	Dementie	-alt= Cue	intyp	2,	24a. Was ar	y prid	ere autopsy findings available or to completion of cause of
							perform 1 Tes 2	njed? dea	ath? ☐Yes 2☐ No
Vital	certificate	o Be	25. Was case referred to medical examiner?	Inpatient 2 ER/Outpatie	oth Oth	or	f Death Check on one		
O	er this	\vdash	27. Minner of Death 28a. Date				ing Home 5 Reside		
SIO	eath. or: Afl	catlo	2 Accident investigation	an, Day Your, mijury		Yes 2 □ No			
Division	after d Diract in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Ptac build	e of Injury - At home, farm, s ing, etc. <i>(Specify)</i>	treet, factory, office		28f. Location (Str City or Town	reet and Number , State)	or Rural Route Number,
	spiral nours a neral / filled		29a. Certifier Certifying Physician: To th	e best of my knowledge, dea	th occurred at the tin	ne, date and	place, and due to the ca	use(s) and mann	ner as stated.
2	within 24 hours after death. To the Euneral Director: After this sertific completely filled in by the funeral director.	edical	(Check only 2 Medical Examinar: On the b	pasis of examination and/or in oner stated.	nvestigation, in my o	pinion, death	occurred at the time, da	ite and place, and	d due to the cause(s)
F	Ton	Σ	29b. Signature and title of certifier		29c. Licens	number	A 41	d. Date signed (Month, Day, Year)
			3A. Name and address of person who completed cau	Xanald N	Print)	0 10	24	1,0110	5
			Robert M. M. Da	nald	Print)	over	-ST 9	ASTON	ND21661
	Sta	-	31. Date filed (Month, Day, Year) 32. F JAN 2 5 2005	gistrar's Signature					
	Registr	ar	GEN & J 2003	low & p	Deep.				

					Ce	rtificate of	f Death		Reg. No. 6	2005	U351
sician		1. Decedent's Name (First, Middle, La	•					2. Date of De Month	Day	Year	3. Time of Death
ledical		Charles Edgar H. 4a. Facility Name (If not institution, gir		er)		Ab City Tourn	or Location of De	Jan	20	2005 County of Death	11:00A
aminer	r	9703 Macks Lane	o direct and mamb	01)				atti		,	
eral		5. Social Security Number 6.	Sex 7.		s. last birthday)	McDa:	r If Under 24 H		rth	Talbot 9. Birthi	place (State or Foreigntry)
tor		213-42-1092	1 ⊠ M 2□F	6	3 Yrs.	Months Days	s Hours Mi	n. (Month, Da Oct 3]			71and
	-	Usual Residence of Decedent 10a. State 10b. County		100.0	· ·						
1				100.0	City, Town or Lo					,	10d. Inside City Limit
Completed by Funeral Director	20	MD Talbot			McDani						1 □ Yes 2X N
	2	10e. Street and Number				10f. Zip Code				on of What Coul	ntry?
eral	- a	9703 Macks Lane	12. Was Decede	nt Ever in	11.0	2164		(C		S.A.	
i j		1 Never Married 2 Married	Armed Force	es?	0.5.	If Yes, specify Cu	Hispanic Origin? (ban, Mexican, Pue	Specify Yes of No orto Rican, etc.)	> 14	Black, White,	
2	ò	3 Midowed 4 □ Divorced	If Yes, Give Year or Date			1 ☐ Yes 2 💢 No	o Specify:		s	pecity: Whi	te
ted	De l	15. Decedent's E			16a. Dece	dent's Usual Occu	upation		16b. Kind	d of Business/In	dustry
o o	ed -	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4)	or 5+\	(Give	kind of work done DO NOT use retir	upation e during most of w red)	orking			· ,
E O	5	12	College (1-40	01 54)		Cook			Coun	try Sto	re
Be		17. Father's Name (First, Middle, Last	1)				18. Mother's N	ame (First, Middle	, Maiden Si	umame)	
ဥ	2	Charles W. O. Ha	arrison				Mary H	Estelle L	ednum	1	
The second		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Stree	et and Number or F	Rural Route Numb	er, City or 7	Town, State, Zip	Code)
		Samantha R. Hai	dy/Daugh		P. 0.	Box 82	St. Mic	haels, M	D 216	63	
		20a. Method of Disposition	75		Place of Dispo	sition (Name of natory or other pla		/25/2005	20c. Loca	tion - City or To	wn, State
<u> </u>		1 □ Burial 2 🛣 Cremation 3 □ 1 □ Donation 5 □ Other (Speci		ch Ch	esapeak	ce Cremat	tion Ctr	, 23/ 2003	teven	sville,	MD
any injury of other freumatic event, the modified Exemples and the modified and ones. To Be Completed by Funeral Director		21. Signature of Funeral Service Lice	trouski C	e.f.s	P Fe	Name and Addr 11ows, I	ress of Facility Helfenbei rrison St	n and Ne	wnam	Funeral	Home D
an		Immediate Cause (Final disease or condition	one cause on each	sed the dea n line. 10 5/	, /		ring, such as cardia				Approximate Interval Between Onset and Death
al Examiner	Lyanning	Immediate Cause (Final	a. Due to (or b. Due to (or c. Due to (or d.	as a conse	quence of):		ing, such as cardin			,	Approximate Interval Between
hysician/Medical Examiner	Ical Evaluated	snock, or near failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or b. Due to (or c.	as a conse	quence of): quence of): quence of): ancy al death 3 [ing, such as cardi		54054	d. Date of delive	Approximate Interval Between Onset and Death
्य हैं by Physician/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{yes} \) 2 \(\text{ No} \)	a. Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown	as a conse	quence of): quence of): quence of): ancy al death 5	Dectopic pregnance	ing, such as cardi	23e. Did to	230	d. Date of delive Month contribute to th	Approximate Interval Between Onset and Death Ty Day Year e cause of death?
by Physician/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a. Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown	as a conse	quence of): quence of): quence of): ancy al death 5	Dectopic pregnance	ing, such as cardi	23a. Did to	23c	d. Date of delive Month contribute to th	Approximate Interval Between Onset and Death Ty Day Year e cause of death? ably 4 Cunknown
by Physician/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a. Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown	as a conse	quence of): quence of): quence of): ancy al death 5	Dectopic pregnance	ing, such as cardi	23e. Did to 1 \(\tau\)	23c	d. Date of delive Month contribute to th No 3 Probi	Approximate Interval Between Onset and Death Onset Interval Death Onse
ত ত De Physician/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown	as a conse	quence of): quence of): quence of): ancy al death 5	Dectopic pregnance	cy	23e. Did to 1 \(\text{Vas} \) 24a. Was autop perfor 1 \(\text{Yes} \)	23c cobacco use (es 2 1 an sy mmed? 2 No	d. Date of delive Month contribute to th No 3 Probi	Approximate Interval Between Onset and Death Ty Day Year e cause of death? ably 4 Cunknown psy findings available
Be Completed by Physician/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months? 25. Was case referred to medical examiner?	Due to (or b. Due to (or c.)	as a conse	quence of): quence of): quence of): ancy al death 5 sulting in the un	Dectopic pregnand Other (specify) _ nderlying cause gi	cy Iven in Part I. 26. Place of De	23e. Did to 1 \(\text{V} \) 24a. Was autop performance of the control of the con	23cobacco use (es 2 1 na sy med? 2 2 No ne)	d. Date of delive Month contribute to th No 3 Prob 24b. Were autoperior to condeath? 1 Yes	Approximate Interval Between Onset and Death Ty Day Year e cause of death? ably 4 Unknown aby findings available pletion of cause of 22 No
ু যু To Be Completed by Physician/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 — Yes 2 — No 9 — Unknown Part II. Other significant conditions of examiner? 1 — Yes 2 — No 25. Was case referred to medical examiner? 1 — Yes 2 — No 27. Manner of Death 1 — Natural 5 — Pending	Due to (or b. Due to (or c. Due to (or c.) Hospital: 1 □ Inpa 28a. Date of Ir (Month, L.)	as a conse	quence of): quence of): quence of): ancy al death 5	DEctopic pregnance of Other (specify)	cy ven in Part I. 26. Place of Dether: 4 \(\text{Nursing} \) at the control of the control o	23e. Did to 1 \(\text{Vas} \) 24a. Was autop perfor 1 \(\text{Yes} \)	23c bbacco use fes 2 1 ssy rmed? 2 2 No ne)	d. Date of delive Month contribute to th No 3 Prob. 24b. Were autor prior to condeath? 1 Yes	Approximate Interval Between Onset and Death Ty Day Year e cause of death? ably 4 Unknown sy findings available in letion of cause of
To Be Completed by Physician/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or b. Due to (or c. Due to (or c.)	as a conse as a c	quence of): quence of): quence of): quence of): ancy al death 5 sulting in the under the u	DEctopic pregnance of Other (specify)	cy ven in Part I. 26. Place of Dether: 4 \(\text{Nursing} \) very v	23e. Did to 1 \(\) \(\	23c bbacco use fes 2 1 an 2 syymed? 2 2 No ne) lence 6 1 low injury o	d. Date of delive Month contribute to th No 3 Prob. 24b. Were autop prior to con death? 1 Yes Other (Specify) courred	Approximate Interval Between Onset and Death Onset and Death Page 1975 Page
rtification; To Be Completed by Physician/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or b. Due to (or c. Du	as a conse as a c	quence of): quence of): quence of): quence of): ancy al death 5 death 5 sulting in the ur 28b. Time of Injury owledge, death	Decurred at the ti	cy ven in Part I. 26. Place of Dether: 4 \(\text{Nursing} \) ver 2 \(\text{No} \) ver 2 \(\text{No} \)	23a. Did to 1 24a. Was autop performed to the control of the contr	23c bbacco use fes 2 \(\text{N} \) an sy med? 2 \(\text{N} \) lence 6 \(\text{Low injury o} \)	d. Date of delive Month contribute to th No 3 Prob. 24b. Were autop prior to con death? 1 Yes Other (Specify courred	Approximate Interval Between Onset and Death Onset and Death Park Park Park Park Park Park Park Park
प्रधारिकाराका: To Be Completed by Physician/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or b. Due to (or c. Due to (or d. d. 23c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown contributing to death to the contributing to death 28a. Date of in (Month, in the contributing, in the contribution).	as a conse as a c	quence of): quence of): quence of): quence of): ancy al death 5 death 5 sulting in the ur 28b. Time of Injury owledge, death	DEctopic pregnance of Other (specify)	cy Iven in Part I. 26. Place of De ther: 4 \(\text{Nursing} \) 17. Yes 2 \(\text{No} \) 18. No copinion, death occopinion, death occopinion, death occopinion.	23a. Did to 1 24a. Was autop performed at the time, of th	23c bbacco use fes 2 \(\text{No} \) an sy med? 2 \(\text{No} \) lence 6 \(\text{Low injury o} \) cause(s) an date and pla	d. Date of delive Month contribute to the No 3 Probe 24b. Were autoper or to condeath? 1 Yes Other (Specify occurred	Approximate Interval Between Onset and Death Onset and Death Part of the Course of death? Ty Day Year e cause of death? ably 4 Unknown pay findings available appletion of cause of death? Acute Number.
Certification: To Be Completed by Physician/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or b. Due to (or c. Du	as a conse as a c	quence of): quenc	DEctopic pregnance of Other (specify) _ other (s	cy ven in Part I. 26. Place of Dether: 4 \(\text{Nursing} \) ver 2 \(\text{No} \) ver 2 \(\text{No} \)	23e. Did to 1 Ves autop perfor 1 Ves ath (Check only of Home 5 Resid 28f. Location (Socity or Tow e, and due to the curred at the time, of	23c cobacco use (es 2 1 1 2 2 No an 2 2 No ne) lence 6 1 2 2 No cow injury of course(s) and fate and pla course(s) and fate a	d. Date of deliver Month contribute to the No 3 Probe Property of condeath? 1 Yes Other (Specify occurred) d manner as stace, and due to igned (Month, L.	Approximate Interval Between Onset and Death Onset and Death Page 1975 Page

			1 - For State Registrar	State of M	arylar		artmen <i>rtificati</i>			nd Men	tal Hygier	/ 11	05	03519
	Physici /Medi		Decedent's Name (First, Middle, La Lamie)	st) Higgins, Jr.						l l	Date of Death Month Numry 18,	²⁰⁰⁵	Yeer	3. Time of Death 19:38 P. M
	Examir Funeral		4a. Fecility Name (If not institution, given Prince George's Hosp 5. Social Security Number 6. S	ital Center	e (In yrs.	last birthday)	If Under	Ct 1 Year	Location of I reverly If Under 24			Prince	Georg	ge's lace (State or Foreign
e Sin	Director		Usual Residence of Decedent	M 2□F		82 _{Yrs.}	Months	Days	Hours	Min.	Pate of Birth Month, Day, Yea Ctober 2,	1922	Coun	th Carolina
	ne Marylar Ba-f ehow	Director	Suul Calofila	nwood	10c. Ci	ty. Town or La	ocation	Gr	enwood				1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	ath with the 23a or 2	ral Dire	10e. Street and Number 215 Cannon Road				10f. Zip			9646		U.S	hat Coun	try?
900	d within 72 hours after death with the Maryland jene. r then "netural", or Items 23a or 28a-1 ehow the Modical Examiner must be notified at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes ZXI If Yes, Give Year or Dates:		1	Was Deced f Yes, spec 1 ☐ Yes 2		spanic Origin n, Mexican, F Specify:	n? (Specify ` Puerto Ricar	Yes or No- n, etc.)	14. Race Black Specify:	, White,	etc.
Maryland 21215-0036	o filed within 72 t Hygiene. other then "netrent, I'm Medical	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	5+)	life. L	dent's Usua kind of wor DO NOT us intenar	k done d e retired)	urina most o	f working		Kind of Bus		Department
yland;	be file Ital Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Last	ggins, Sr.				1	18. Mother's		nie Mae A	n Sumame)	
	s 1 and 2 should if Health and Meritem 27 is marke other traumatic		19a. Informant's Name/Relationship (Mrs. Alberta Pearce			5108	Flintr	idge l			ite Number, City 11e, Mary		tate, <i>Zip</i> 20784	Code)
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Denation 5 ☐ Other (Specif	y)	Spr.	Place of Dispo- cemetery, creating Field Ceme	Bapti. tery	st CH	irch Jar	Date Lary 2	20c. 5,2005 Fde	efield	ity or Too Sout	wn, State th Carolina
Bai	Dermit. Departing Imports eny inju		21. Signature of Funeral Service Licer	· Jude	118	4	. Name and 339 Hu	Address	s of Facility ace, N.I	E. Rolli Wash	ns Funera Ington, L			
	Physician /Medical Examiner physician and physician and physician and the principle of the physician and physician	Examiner	23a. Part. Enter the disease, or combined, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to induction cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Cardio	Wascu a conseq escler	uence of): OSIS— Co	ease		, such as cal	rolac or resp	pratory arrest,			Approximate Interval Between Onset and Death
.O. Box 68760,	the death certifi y the attending iched for use as	by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	I death 3 🗌	Ectopic pre					23d. Date Month		y Day Year
ords, P	w requires that been signed b should be deta	ed by P	Part II. Other significant conditions of	ontributing to death bu	ut not rest	ulting in the un	derlying ca	use giver	n in Part I.	_ 2	3e. Did tobacco	3.		e cause of death?
al Records	The law ate has b page 2 si	Completed								-	4a. Was an autopsy performed? □ Yes 2⁄2 N	pride:	or to com ath?	sy findings available pletion of cause of
Vital		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No	Hospital:		50/0		Other			ck only one)			
ō	Phys er this eral di	.: To	27. Manner of Death	1 ☐ Inpatie	y	ER/Outpatient 28b. Time of	100	c. Injury	4 Nursir		Residence			
Division	Attending r death.	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			Injury	М	Work?	es 2 No		ocation (Street a			Route Number
Ö	i Çife		29a. Certifying Ph	ysician: To the best of	of my know	wledge, death	occurred a	t the time	date and n	lace and du	ity or Town, Stat	e)		and and
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	one)	and manner sta	examinat	tion and/or inv	estigation, i	n my apii	nion, death o	occurred at t	he time, date an	d place, and	d due to t	he cause(s)
	2 2 3		29b. Signature and title of ceptiter	00 m	W,	W	1	License	47			ry 21,		ay, Year)
	alc		James Oliver, MD	completed cause of de 422 1st Plac	e, N.	23a ype. F W. WShi	rint) ngton,	D.C.	20011					
	Sta Registr	7	31. Date filed (Month, Day, Year)	32. Registra	r's Signal	ture								

			1 - For State Registrar	State of Man		artment of H			ene 2005	03526
	Physic		1. Decedent's Name (First, Middle, Las Garey Henry	st)				2. Date of Death Month January 20	Day Year	3. Time of Death 1800 P M
1	/Medi Examir		4a. Facility Name (If not institution, give	,		4b. City, Town, or Cheve	Location of Death		4c. County of Death Prince Ge	
	Funeral Director		5. Social Security Number 6. S 579–70–4078		yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) 01/26/19	(ear) 9. Birthp	place (State or Foreign ortry)
	death with the Maryland ma 23a or 28e-1 ehow Embal be notified at	ō	Usual Residence of Decedent 10a. State 10b. County DC	10	c. City, Town or Lo Washing				1	0d. Inside City Limits 1 ☐ Yes 2X No
	or 28e-	Director	10e. Street and Number			10f. Zip Code		100	. Citizen of What Cour	
	ath w	ral	5101 Fitch Street			200			U.S.A.	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or itama 23s or 28e-f show any highry or other traumatic event, the Medical Eventuar must be notified at ances.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ Yes If Yes, Give Year or Dates:	'	Was Decedent of Hi f Yes, specify Cubai 1 ☐ Yes 2∰No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	14. Race - Americ Black, White, Specify: Bla	
21215-0036	ithio 72 ho ne. san "natur Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	uring most of worl	sing 16	tb. Kind of Business/Inc	
7	lled w tygier har th		12th 17. Father's Name (First, Middle, Last)		P	ainter			Self	
Maryland	lould be fi I Mental H narked ot natic ever	To Be	John Henry				Gor	e (First, Middle, Ma nell Bect	on	
Mai	d 2 st th and 7 Is n traun		19a. Informant's Name/Relationship () Gornell Herring –						City or Town, State, Zip	
Baltimore,	ages 1 and of Heali t: If item 2 f or other	0.000	20a. Method of Disposition 1X Burial 2 Cremation 3	Removal from State	Ob. Place of Dispo- cemetery, cren	sition (Name of natory or other place)	Date 20	ington, D.(wn, State
Baltir	permit. P Departme Importan eny injur.		21. Signature of unetal Service Licen			Name and Address			linton, Mar eral Servio	
	40 = 0 a		222 Part Edit the disease of a mile	enul	P	0. Box 4	16; Suit	land, Mar	vland 2075	52
	Physician /Medical Examiner	ler	23a. Part. Ertiar the disease, of composition shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. 2 to to (or as a co	nsequence of):	lamm	story &	espiratory arrest	e dyndu	Approximate Interval Between Onset and Death
58760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical Examiner	fl any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a col	nsequence of):	nia				
.O. Box (res that the death certific signed by the attending p be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pr 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	ry Day Year
Hecords, P.	w requires that been signed I should be det	by	Part II. Other significant conditions co	ntributing to death but no	t resulting in the un	derlying cause giver	n in Part I.	23e. Did tobac	co use contribute to the	1/
	The ate h page	Completed						24a. Was an autopsy performac	prior to com death?	sy findings available apletion of cause of
VItal	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				(Check only one)		
on of	ding Phy h. After this funeral d	tlon: To	1 Yes 2 No 27. Minner of Seath 1 Natural 5 Pending investigation	1 npatient 28a. Late of Injury (Month, Day Yea	2 ER/Outpatient 28b. Time of Injury	28c. Injury Work?	4 Nursing Ho	me 5 Residence 28d. Describe how i	e 6 ☐Other (Specify) njury occurred	
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (Sp.	At home, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	t and Number or Rural tate)	Route Number,
	To the Hospital within 24 hours and To the Funeral completely filled	edical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	sician: To the best of my ner: On the basis of exar and manner stated.	knowledge, death mination and/or inve	occurred at the time estigation, in my opin	, date and place, nion, death occurr	and due to the cause ed at the time, date	e(s) and manner as sta and place, and due to t	ted. the cause(s)
	To To Ten	Σ	29b. Signature and title of certifier	7		29c. License	number	29d.	Date signed (Month &	ay, Year)
	epc.		1 Conte	re	~	13	03/8	- 11	120/05	
	9		30. Name and address of person who co	nis, MD.	3001+	tospita	1 Drive	Chever	ly mary	land
	Sta Registra		JAN 2 5 2005	32. Registrar's S	ionature	-		/	0 1	

			1 - State Registrar	Cei	rtificate of Death	Mental Hyg	Reg. No.2005 03521
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last Mildred D. Aa. Facility Name (If not institution, give Washington Adventi	Heflin street and number)	4b. City, Town, or Location of Dea	2. Date of Dea Month January	Day Year
D	uneral		5. Social Security Number 217–42–4011 15 Usual Residence of Decedent	x 7. Age (In yrs. last birthday) M 2 F 88 Yrs.	If Under 1 Year If Under 24 Hr. Months Days Hours Min		9. Birthplace (State or Foreign Country) 1916 Washington, DC
h the Marylan	or 28a-f show a notified at	Director	Maryland Prince Ge	eorge's Bladensbu			10d. Inside City Limits t☐ Yes 2 ☐ No 10g. Citizen of What Country?
Ind 21215-0036 be filed within 72 hours after death with the Maryland	Department of result and western registers, or fleme 23a or 28a-f show sny injury or other traumatic event, the Medical Examinar must be notified at once.	Funerai	5999 Emerson str 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1□ Yes 2☐ No Specify:		Jnited States 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036 at 2 should be filled within 72 hours at the and Mental Huciane.	r than "natural Tre Medical E	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12	ucation 16a. Dece (Give (College (1-4or 5+)	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) s Clerk	orking	16b. Kind of Business/Industry Private
aryland should be file	marked othe	e	17. Father's Name (First, Middle, Last) (Unobtainable) Stell 19a. Informant's Name/Relationship (T	ype, Print) 19b. Mailir	Emma C	ime (First, Middle, 1emenstor Jural Route Numbe	1
Baltimore, Ma permit. Pages 1 and 2:	of the state of th		Mary H. Fry / Daug 20a. Method of Disposition MXBurial 2 Cremation 3 1 4 Donation 5 Other (Specify	20b. Place of Dispo cometery, crer	Taylor st. Blad sistion (Name of natory or other place) coln Cemetery 1/2	Date	MD 20710 20c. Location - City or Town, State 3rentwood, MD
Baltil Permit:	importar any inju	- 55	21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease. or comp	iee 22 3 ilications that caused the death. Do not ent		Road Bre	entwood, MD 20722
/M	ysician ledical aminer		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a consequence of):	NIA.		Interval Between Onset and Death
68760, lificate be executed	physician and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate case of the conditions of	Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	elin Arsons L.	75	
O. Box the death cer	ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ords, P	should be deta	by	Part II. Other significant conditions co	ntributing to death but not resulting in the u	nderlying cause given in Part I.		bacco use contribute to the cause of death? es 2 \(\overline{X} \)No 3 \(\overline{P} \) Probably 4 \(\overline{U} \)Unknown
tal Rec		e Completed	25. Was case referred to medical		26 Place of De	24a. Was a autops perfor 1 Yes	sy prior to completion of cause of death? **T No 1 Yes 2 No
Vision of Vita Attending Physician:	er this cer teral direct	To B	examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: Timpatient 2 ER/Outpatien 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	nt 3 DOA Other: 4 Nursing	Home 5 Resid	ence 6 Other (Specify) ow injury occurred
5 5	within 4 moust after the conflicate ha within 4 moust after this centificate ha completely filled in by the funeral director, page 2	Certification:	1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	M 1 Yes 2 No	28f. Location (S. City or Town	treet and Number or Rural Route Number, n, State)
To the Hospital	E Funeral I	Medicai C	29a. Certifying Phy (Check only one) 1 Certifying Phy 2 Medicef Exem	rsician: To the best of my knowledge, death iner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and plac vestigation, in my opinion, death occ	e, and due to the curred at the time, d	rause(s) and manner as stated. date and place, and due to the cause(s)
10 1	Tothe	Me	29b. Signature and little of certifier	ver/	29c. License number MAD 576	14	29d. Date, signed (Month, Day, Year)
3	gC Sta	te_	30. Name and address of person who court Dr. Devore 31. Date filed (Month, Day, Year) 11. N. 2. 5. 2005	omple d cause of death (Item 23a) (Type, 7600 Carro 32. Registrar's Signature		Park, MD	

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Date Month 01 Day 17 2005 Physician Elwood N. Hampton, Jr. 9:15 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14009 Wildwood Dr Silver Spring Montgomery If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month 13-1928 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** M 2□F Months Days Hours 76 Washington ,DC 577-30-8236 Yrs. **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County Hygiene. other then "naturel", or items 23a or 28e-f show ent, the Mydical Examinar must be outlified at 1 ☐ Yes 2 No Maryland Montgomery Silver Spring Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14009 Wildwood Dr 20905 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) George Washington College (1-4or 5+) Engineer University other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth eny injury or other traumatic event sone. Lillian Hall Elwood N. Hampton Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cherryhill Rd #203 Beltsville,MD 20705 Elwood HamptonIII./son 11453 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ExBurial 2 ☐ Cremation 3 ☐ Removal from State Parklawn cemetery 01/20/2005 Rockville ,MD * 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Ser 22. Name and Address of Facility Hines -Rinaldi Funeral Home 1800 New Hampshire Ave; Silver Spring, MD20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine requires that the death certificate be executed burial-transit that initiated events attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 Tyes 24 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1 ☐ Yes 30 Division of Vital Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one, 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Pesidence 6 Other (Specify) 2 D NO this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1 Natural 5 Pending 2 🗌 No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu and title of dertifier 20 05 10 30. Name and address of passon who completed cause Aldolph Johnson, M.D. 12520 Properity Dr #150 th (Item 23a) (Type, Print) of de #150;Silver Spring,MD 20905 31. Date filed (Month, Day Year) JAN 2 1 2005 Registrar

			1 _ Stata	Department of Health and I Certificate of Death	Mental Hygie	ene 2005 00500
	Physici	ian	Registrer Decedent's Name (First, Middle, Last) Launa Beatrice Harri		2. Date of Death February	Pay, 200° 3:50 AM _M
	/Medi Examir		4a. Facility Name (If not institution, give street and number) Citizens Nursing Home	4b. City, Town, or Location of Death Frederick	1	4c. County of Death Frederick
1	Funeral Director		5. Social Security Number 213-60-8124 6. Sex 1 □ M 2	t birthday) If Under 1 Year If Under 24 Hrs. Yrs. Months Days Hours Min.	8. Date of Birth April Day, y	9. Birthplace (State or Foreign , 1915 Virginia
	Maryland I-f show	tor		own or Location derick		10d. Inside City Limits 1 XYes 2 □ No
	h with the	al Director	10e. Street and Number 1900 Rosemont Avenue	10f. Zip Code 21702	10g	. Citizen of What Country?
980	s 1 and 2 should be filad within 72 hours after death with the Maryland of Health and Mental Hygjene, item 27 is markad other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Eventret frust be notified at	Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ☒ ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - American Indian, Black, White, etc. Specify: White
1215-0	vithin 72 ho ne. han "natur Medical	mpleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) I I amount of the control of the	king 16	b. Kind of Business/Industry
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importants If item 27 is marked other than any injury or other traumatic event, ID. M. ODGE.	To Be Co	17. Father's Name (First, Middle, Last) Andrew Godfrey Bolinger		ne (First, Middle, Mai e Estella	
	i and 2 should be Health and Mental tem 27 is markad of other traumatic even		19a. Informant's Name/Relationship (Type, Print) Mrs. Esther V. Perkins, daughter	19b. Mailing Address (Street and Number or Ru 5631 Crabapple Drive	ral Route Number, C , Frederic	ity or Town, State, Zip Code) Ck, MD 21703
Baltimore,	Pagas 1 a nent of Hei int: If item iry or otha		20a. Method of Disposition 1\(\sumething \text{Burial}\) 2 \(\sumething \text{Cremation}\) 3 \(\sumething \text{Removal from State}\) 1\(\sumething \text{Burial}\) 2 \(\sumething \text{Cremation}\) 3 \(\sumething \text{Removal from State}\) 20b. Place cern cern 1\(\sumething \text{1}\) Donation 5 \(\sumething \text{Other}\) (Specify)	e of Disposition (Name of effect cremators or other place) Feb. 4, 2		c. Location - City or Town, State Frederick, MD
Balti	permit. Pagas. Department of I Important: If ite any injury or of once.		21. Signature of Funeral Service Licensee MOO2	55 Keeney and Basford 106 East Church St	PA Funera	al Home ick, MD 21701
	Prrysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	2 Disease	or respiratory arrest,	Approximate Interval Between Onset and Death Onset and Death
3760, 🕏	eath certificate ba exacuted attending physician and for usa as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence			
.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death 9 Unknown	ath 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
rds, P.	equires tha en signed buld be del	by	Part II. Other significant conditions contributing to death but not resultin	ig in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death? No 3 - Probably 4 - Unknown
al Records,		Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
ion of Vital	ling Phys I. After this Iuneral di	ation: To Be			th (Check only one) ome 5 Residence 28d. Describe how in	e 6 □Other (Specify)
Division	tal or Atta s after de al Directo ad in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely fillad in by tha t	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowled (Check only one) Medical Examiner: On the basis of examination and manner stated.	dge, death occurred at the time, date and place, and/or investigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
•	with To I	Σ.	29b. Signature and title of certifier aufmun	29c. License number \\ \mathcal{D}^{-1} \ 397/		Date signed (Month, Day, Year) ebruary 1, 2005
	6		30. Name and address of person who completed cause of death (Item 23 Robert L. Kaufmann, M.D., 300	West Ninth Street, F	rederick,	MD 21701
	Sta Registr		31. Date filed (Month, Day, Year) 32 Registrar's Signature FEB 2005	Sparke		

			1 - State of State of Registrar	Maryland / Depa	artment of I			ene2005	03524
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last) Frederic 4a. Facility Name (If not institution, give street and num	ber)	Het 4b. City, Town, o	Zel	2. Date of Death Month	Day Year	3. Time of Death
	Funeral Director		168 24 1167 18€ M 2□F Usual Residence of Decedent	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	8. Date of Birth Month, Day, Y Aug. 5 1	9. Bit 930 Per	thplace (State or Foreign ountry) nns yl va ni a
36	hours after death with the Maryland turel', or Items 23s or 28a-f show at Examiner russ be notified at	y Funeral Director	1 Never Married 2 Married 1 Yes	dent Ever in U.S. 13.	10f. Zip Code	20832 Hispanic Origin? (Spec an, Mexican, Puerto F Specify:	U	n. Citizen of What Content of	tes erican Indian,
Maryland 21215-0036	filed within 72 Hygiene. ether than "net	Be Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-12) 17. Father's Name (First, Middle, Last)	16a. Dece (Give life.	dent's Usual Occur	pation during most of workin d)	g	b. Kind of Business	/Industry
arylan	d 2 should be th and Mental 7 Is marked of treumetic eve	To B	Theodore Hetzel 19a. informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	Rebecca	Route Number, C		Zip Code)
	as 1 and of Healt Item 2		Frederic J. Hetzel / Sor 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from S	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place	ce)	ate 20	c. Location - City or	Town, State
Baltimore,	permit. Page Department Importent: If eny injury of once.		*4 □Donation *5 □Other (Specify) 21. Signature of Funeral Service Licensee **Machine Alexandre Alexandr		itan Crer ^{2. Name and Addre} Muriel	m. 1/21 H. Barber ox 5038,	Funeral	Alexandri Home	
8760,	Physician and physician and physician and physician and the burat-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	ing Cal					Approximate Interval Between Onset and Death
O. Box 6	death certifi e attending I id for use as	Physiclan/Medlcal	in the past 12 months?	nt at time of death 5 ☐	□Ectopic pregnancy □ Other (specify)	/		23d. Date of del	ivery Day Year
S, D	es be	by	Part II. Other significant conditions contributing to dea	th but not resulting in the u	nderlying cause giv	ren in Part I.	23e. Did tobac	/	the cause of death?
Vital Record	The law ate has b page 2 sl	Completed	OF Was and otherwise medical				24a. Was an autopsy performed	prior to death?	atopsy findings available completion of cause of
o	ding Phys h. After this funeral di	ertification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 In a large of Death 1. Natural 5 Pending (Month) 2 Accident investigation	patient 2 ER/Outpatien Injury 28b. Time of Injury	f 28c. Injur Wor	y at 28		e 6 Other (Spe	cify)
Divis	or A	Certiflo	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of buildin	f Injury - At home, farm, str g, etc. (Specify)	reet, factory, office	28	If. Location (Stree City or Town, S	t and Number or Ru tate)	ıral Route Number,
	To the Hospital within 24 hours a To the Funerel C completely filled in	l edical	29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner.	is of examination and/or in	vestigation, in my o	pinion, death occurred	d at the time, date	and place, and due	to the cause(s)
•	vitit Voit Con	2	30. Name and address of person who completed cause Or Eric Brishes Resident Johns	of death (Item 23a) (Type, Hopk / 15 Hospitalistar's Signature	Print)	5-00	29d.	Date signed (Month	n. Day, Year)
11	Sta Registr	te	31. Date filed (Month, Day, Year) 32. Jan 2 4 2005	jistrar's Signatus	parli	m worte S11	eet Dalt	marelVac	yong LILT/

			1 - For State Registrar		Maryland		artment <i>tificate</i>			and M		eg. N&2 0	05	03525
	Physici /Medie		Decedent's Name (First, Middle, VINH T. HO	Last)							2. Date of Dea Month JANUARY	Day	Year 05	3. Time of Death 10:00PM
	Examir		4a. Facility Name (If not institution, SUBURBAN HOSP)	TAL			4b. City, To	ESDA	,MD			4c. Count	y of Death	ERY
	Funeral Director		5. Social Security Number 214-47-2365 Usual Residence of Decedent	6. Sex 7 1 □ M 2 😿 F	. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Months I	Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day JULY 14	Year) ,1921		place (State or Foreign ntry) TNAM
	Maryland	tor	10a. State 10b. County MD MONTGON	ŒRY		, Town or Lo	cation							10d. Inside City Limits 1
	with the 3e or 28 if be not	I Director	10e. Street and Number 2418 STRATTON	DR.			10f. Zip C	ode 854			1	0g. Citizen of		ntry?
980	72 hours after death with the Maryland naturel', or Items 23e or 28e-1 show dreal Examiner must be inclifted at	by Funeral	11. Marital Status 1 ☐ Nøver Married 2 ☐ Marrie 3 ☐ Xilvidowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	es? No	Ji		nt of His y Cubar	spanic Orig n, Mexican, Specify:	gin? (Spe , Puerto I	ecify Yes or No- Rican, etc.)	14. Ra	ce - Americk, White,	can Indian, etc.
Maryland 21215-0036	vithin ne. hen.*	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12		lor 5+)	(Give . life. [lent's Usual (kind of work DO NOT use MAKER	doné di retired)	tion uring most	of workir	ng	16b. Kind of B		dustry
land	ud be filed lental Hygi ked other ic event,	To Be (17. Father's Name (First, Middle, L. TOAI T. HO	ast)						r's Name H T.	(First, Middle, i	Maiden Sumar	ne)	
Mary	nd 2 shou lth and M 27 le mar treumet	}-	19a. Informant's Name/Relationshi						nd Number	r or Rura	I Route Number			Code)
Baltimore,	permit. Pages 1 and 2 should be filed w Dapartment of Health and Mental Hygie Importent: If tiem 27 Ie marked other the eny injury or other treumetic event. If once.		20a. Method of Disposition 1 Burial 2 Cremation 3		ate ce	ace of Dispos metery, crem VA CRI	sition (Name natory or othe	of er place)	D	ate	20c. Location	City or To	own, State A 22203
Balti	permit. Departm Importe eny inju		21. Signature of Funeral Service Li	**	,	22	. Name and	Address	of Facility	ARL	INGTON :	FUNERAL	HOM	E
8760,	death certificate be executed x x x x a stending physician and upper certificate and increase the burial-transit	cal Examiner	23a. Part1. Enter the disease, or of shock, or heart albire. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last	a. Due to (or Due to (or c.	ised the death, the line. ASTATIC as a conseque as a conseque as a conseque	ence of):		of dying	, such as c	eardiac o	respiratory arro	sst,		Approximate Interval Between Onset and Death WEEKS
P.O. Box 68	ath certifi ttending (or use as	by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown		h 2 ∏Fetale nt at time of de	death 3	Ectopic pregi Other (speci						te of delive	ory Day Year
	w requires that the de been signed by the s should be detached t		Part II. Other significant condition	s contributing to deal	th but not resul	lting in the un	derlying caus	se giver	in Part I.		23e. Did tob	_		ne cause of death?
of Vital Records	The law ate has b page 2 si	e Completed	25. Was case referred to medical						Oe Diago			ned?	orior to cor death?	psy findings available inpletion of cause of 2 No
Division of Vi	or Attending Phye Iter death. Director: After this in by the funeral dii	Certification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga 2 Accident investiga 3 Suicide 6 Could no determin	t be 28e. Place of	-	ER/Outpatient 28b. Time of Injury	28c.	Other Injury a Work?	4 □ Nur	sing Hom 2	(Check only one 5 □ Reside 8d. Describe ho 8f. Location (Str City or Town	nce 6 Oth w injury occurr	red	I Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	edical C	29a. Certifier Check only one) Certifying	Physician: To the becaminer: On the base and manner	is of examination	riedge, death on and/or inv	occurred at t estigation, in	the time my opi	, date and nion, death	place, a	nd due to the ca d at the time, da	use(s) and ma te and place,	nner as st and due to	ated. the cause(s)
)	Your Within Some	W	29b. Signature and title of certifier Welsone du Co	PMD			29c. L	icense) S (number 6/6		29	ANUAN	(Month, I	Day, Year)
•	Sta Registr		30. Name and address of person with NELSO B KAL 31. Date filed (Month, Day, Year) JAN 24	1005 37 Reg	of death (Item:	Pare Chil	Print)	ive	# 32	.7 0	olpey,	MD 20	832	0ay, Year)

PD)		1 - For State Registrar		State of	Maryla	nd / Depa		t of H	lealth a		lental Hyg		005	
	Physic	0.0	1. Decedent's Name (First, Midd	lie, Last,)							2. Date of Dea	ıth		3. Time of Death
	/Medi		G ayle		Valter		Holle:					Januar	y 28	, 20Ö	0916 A M
	Examir	ner	4a. Facility Name (If not institution		street and num	ber)				r Location of	Death		4c. (County of D	eath
		3	5626 Hutton Ro 5. Social Security Number	ad 6. Se	,	7 A== /f=		Oak1		I II I I I I I I I I I I I I I I I I I	A Usa			rett	
	Funeral Director		213-44-1758 Usual Residence of Decedent		M 2□F	60	s. last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birtl (Month, Day Nov. 5,	, Year)		Birthplace (State or Foreign Country) Maryland
	/land		10a. State 10b. Count	/		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Martal Hygiene, item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Modical Eventinar must be notified at	ctor	MD	Garr	ett			C	akla	and					1 ☐ Yes 2 🛣 No
	or 28	Completed by Funeral Director	10e. Street and Number					10f. Zip	Code				l 0g. Citiz	en of What	Country?
	s 23a	ral	5626 Hutton Ro		10.111					21550				USA	<u> </u>
	ter de Itam	Ľ,	11. Marital Status 1 ☐ Never Married 2 ☐ Ma		12. Was Deced Armed Ford 1 ☐ Yes	ces?	J.S. 13. 1	Was Deced Yes, spec	ent of Hi ify Cuba	ispanic Origi In, Mexican,	in? (Spe Puerto	ecify Yes or No- Rican, etc.)	1.	4. Race - Al Black, W	merican Indian, hite, etc.
920	urs af	by	3 ☐ Widowed 4 🙀 Divorce		If Yes, Give			I ☐ Yes 2	No No	Specify:				Specify:	White
Maryland 21215-0036	72 ho	ted	15. Deceder (Specify only higher	nt's Edu	cation		16a. Deced	lent's Usua	I Occupa	ation	, ,		16b. Kin	d of Busine:	ss/Industry
2	ithin 7	nple	Elementary/Secondary (0-12)	isi gradi	College (1-	4or 5+)	life.	OO NOT us	e retired	during most (of worki	ng			
2	filed w Hygier othar th	S	6th 17. Father's Name (First, Middle,	(= = 1)					True	ck Dri				Timbe	er
anc	ould be fi Mantal H arked ot atic ever	Be	Walter		hingto	•	Ho11					(First, Middle,	_		. 1 . 1 3
2	should I nd Mani marke umatic	ပို	19a. Informant's Name/Relations			.1			(Street a		tri	l Route Number	lay	•	ohold
	and 2 salth ar n 27 is		Linda S. Holle									t. Lake			
ē,	es 1 ar of Hea fitem r othe		20a. Method of Disposition				Place of Dispo	sition (Nam	e of						or Town, State
Ê	Pages nent of I int: If its		1 XBurial 2 Cremation 14 Donation 5 Other (S	3 ⊟R Specify)	emoval from Si	late	cemetery, cren crett C	•		1	1/31	/05	∩al-1	and	Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service	License		Gui			-	s of Facility	1/31			econd	
m —	8258		Byallon	7 1	levis		St	ewart	Fur	neral	Home				21550
			23a. Part1. Enter the disease, o shock, or heart failure. List	r compli	cations that car	used the dea ch line.	th. Do not ente	r the mode	of dying	g, such as ca	ardiac o	r respiratory arr	est,	TIQ.	Approximate Interval Between
0	Pnysician		Immediate Cause (Final disease or condition		(000	olicas	tions	OF	ch	Score	. 0	John	.50		Onset and Death
	/Medical Examiner		resulting in death)		Due to (o	as a consec	quence of):			1100110		acolec.	1131		years
	- Zammer	-	Sequentially list conditions, if any, leading to immediate	b	. Due to /o										
	tad nsit	nlne	Cause (Disease or injury	<	00 01 900	r as a consec	quence or):								
	execu n and al-tra	Examiner	that initiated events resulting in death) Last	c	Due to (or	r as a consec	quence of);								
2/60	ate be executad hysician and the burial-transit	call													
õ	tificat ng phy as th	773		-											
X POX	death certificate be executad e attending physician and od for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23	3c. If yes, outco	me of pregna		Ectopic pre	gnancy				23	d. Date of d	elivery
	e dea the at	sici	in the past 12 months? 1 Yes 2 No			nt at time of d		Other (spe						Month	Day Year
7.	ires that the de signad by the a I be detached i	Phy	9 Unknown Part II. Other significant conditions				10								
ďS,	law requires that the as been signad by th 2 should be detache	d by	raitii. Other significant conditi	ons con	inbuting to dea	in but not res	suiting in the un	derlying ca	use give	n in Part I.					to the cause of death? Probably 4 Unknown
ecords	w require been sig	etec									_	-	s 2 🗆	NO 3 1	Probably 4 Onknown
ě	9 4 9	Completed			,							24a. Was ar autops	/	24b. Were a prior to death?	autopsy findings available completion of cause of
N I Gal	ilcian: Th certificate rector, pag	မ Co	25. Was case referred to medica									1XYes 2	□ No	1/SYe	s 2 No
>	Physician: this certific ral director,	0 8	examiner?		ospital:	nationt 2	ER/Outpatient	3[] 004	Othe			(Check only one		70	
0	g Phys er this eral di	n: T	27. Manner of Death		28a. Date of (Month,		28b. Time of		c. Injury Work	4 🗆 (40) SI		8d. Describe ho			ecify) At Scene
0	ath. r: Aft	atlo	1 Natural 5 ☐ Pendir 2 ☐ Accident investi		(Month,	Day rear)	Injury	М		? es 2 □ No	,				
DIVISION	r Atterdering inector	ertification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		28e. Place of building	Injury - At he	ome, farm, stre	et, factory,	office		2	8f. Location (Str City or Town	eet and h	Vumber or F	Rura / Route Number,
_	ital ours aft	O			1						_W_				
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifyir (Check only one) 2 Medicel	g Physi Exemin	ician: To the bo er: On the basi and manne	is of examina	wledge, death ition and/or invi	occurred at estigation, i	t the time n my opi	e, date and printed in	olace, ai	nd due to the ca d at the time, da	use(s) an te and pl	d manner a ace, and du	is stated. e to the cause(s)
	To the Within To the comple	Me	29b. Signature and title of certifie	(00	29c.	License	number		29	d. Date s	igned (Mon	nth, Day, Year)
,			Mar.) 1	On	-14	Waln	0	.C.1	1.E.			ໂລກນາຕ	20 20	, 2005
			30 Name and address of person	who con	npleted cause,	of death (Item		rint)							
			KATRICIA ASI	MI	CA-131	Jaku		Penn	Stre	eet, B	alti	imore, M	lary1	and 2	1201
	Sta Registra		31. Date filed (Month, Day, Year)	n ·		istrar's Signa		Bosel	e e						
Ĩ.	, negisti	All .	JAN	3 1	2005	A. Solow	1 100	A. War	C						

			1 - State of Marylan Registrar Amend Items 23d,25 per M	nd / Depa E, G840	artment of He	ealth and M	1ental Hyg	jiene 2 ()	05	03	527
	0		1. Decedent's Name (First, Middle, Last)				2. Date of Dea	th		3. Time of	Death
ı	Physici		Henrietta Hicks Jones				Jan.	Day 21. 2	Year 2005	2:30	A M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	Home	4b. City, Town, or L	ocation of Death	oan.	4c. County		7 2.50	
			Open Arms Assistant Living Nu		Sudlersy	71110		Oucon	٨٠٠٠		
	Funeral		Social Security Number 6. Sex 7. Age (In yrs.)		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Queen		nes lace (State o try)	r Foreian
L	Director		199-18-8771 1□ M 2♥F 101	Yrs.	Months Days	Hours Min.	Feb. 1, 1		Mary:		
	P .		Usual Residence of Decedent								
	how		10a. State 10b. County 10c. C	ity, Town or Lo	cation				1	0d. Inside Cit	ty Limits
	Ma F	Director	Maryland Queen Annes Su	ıdlersv	ille					1 Yes	2 🗌 No
	or 28	ire	10e. Street and Number		10f. Zip Code		1	0g. Citizen of W	Vhat Coun	itry?	
	23e c		104 Charles Street		21668			USA			
	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show is Madical Examinal must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in L Armed Forces?		Was Decedent of Hisp	panic Origin? (Spe	ecify Yes or No-	14. Race	- Americ		
9	after or ite	교	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 😿 No		If Yes, specify Cuban,		Hican, etc.)	Blac	k, White,	etc.	
ဗ္ဗ	ours Fig.	þ	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2.127No	Specify:		Specify.	: 1	31ack	
21215-0036	72 hc	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupati	ion	ina	16b. Kind of Bu			
2	thin .	ğ	Elementary/Secondary (0-12) College (1-4or 5+)	life.	kind of work done du DO NOT use retired)	ring most of worki	ing				
7	gien erth	5	8	Hom	e Maker			Some on	e els	se's h	ome
g	al Hy l oth	Be (17. Father's Name (First, Middle, Last)		1	8. Mother's Name	(First, Middle, I	Maiden Sumam	e)		
ā	ould be i Mental I arked o	To	James Henry Hicks			Hency	Morr	is			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28a-f show any injury or other traumatic avant, the Medical Examinat must be notified at once.		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and				State, Zip	Code)	
	alth a		Lillian Curtis / Cousin	109	Winding Ri	dre Rd	Dover.	Delawa:	re 19	904	
more,	s 1 a f Hea item othe		20a. Method of Disposition 20b.	Place of Dispo	sition (Name of			20c. Location -			
9	age ant o nt: If		Dunal 2 Command 3 Chemoval Itom State		natory or other place)						
alti	artme ortan injur		21. Signature of Funeral Sérvice Licenses		field Cem. Name and Address		3-2005	Centrev	ille,	Maryla	and
Ba	permi Depa Impo any ir		(XILIACO)	-	Bennie Sm	ith Fune	ral Hom	е			
	-		23a. Part Enter the disease, or complications that caused the dea	th. Do not ent	717 W. Di	vision S	treet,	Dover, Do	elawa		
		9	shock, or heart failure. List only one cause on each line.				- 0			Approximate Interval Betwoonset and D	ween
	Physician		Immediate Cause (Final disease or condition resulting in death)	CONG	estive t	teart.	tallur	e)		011301 4110 2	- Call
	/Medical Examiner		Due to (or as a consec	quence of);							
í.		_	Sequentially list conditions b. Flavov	1 ce	Flore						
	D III	iner	if any, leading to immediate cause. Enter Underlying	quence of):		10-					
	and trans	Examin	Cause (Disease or injury that initiated events c.	ie	Hemu	179					
Ö,	icate be executed physician and the burial-transit	<u> </u>	resulting in death) Last Due to (or as a consec	quence of):	ALCOHOL: NA	LONGER DE	(m				
8760,	ate b hysic fhe b	dlcal	d. A Sirve	- 6-5	HO Wa	piration	(Term	inal)			
9			IF FEMALE:			TIFICATION APPROV	A CONE	MAINER			
ŏ	death certific e attending p d for use as	Physiclan/M	23b. Was decedent pregnant 23c. If yes, outcome of pregnant		Ectopic pregnancy	1	ED BY MEDICAL	23d. Date		у	
m	0 0 0	Sicl	1 Yes 2 No 4 Pregnant at time of c		Other (specify)	TON APPROV		Mon	th I	Day Y	ear
<u>.</u>	at the de by the a tached	hy	9 LI Onknown		CER	Uklow					
_	The law requires that the tee base been signed by the base been signed by the bage 2 should be detache	by P	Part II. Other significant conditions contributing to death but not res	sulting in the ur	nderlying cause given	in Part I.	23e. Did tob	acco use contri	bute to the	a cause of de	eath?
ecords,	w require been sig should b						1 ☐ Ye	s 2 🗆 No	3 🗌 Proba	ibly 4 🖽 Ui	nknown
8	s bee	Completed					24a. Was an	24b W	ere auton	sy findings a	ıvaılahle
Z.	: The law cate has b page 2 s	Ĕ					autopsy	/ pr	rior to com	pletion of ca	use of
Vital R			25. Was agos retarred to madical				1□ Yes 2	No 1	☐ Yes 2	2 🗆 No	
Ĭ	sicien: certific rector,	Be	25. Was case referred to medical examiner? Hospital:		2 Other:	6. Place of Death					
O	Phys this al di	- To	X res ZZTTO 1 □ Inpatient 2 □	ER/Outpatien	I 3∐ DOA	4 M Nursing Hon)	
Division of	ding P. h. After funera	lon	1 X Natural 5 ☐ Pending (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		28d. Describe ho	w injury occurre	d		
S	Attend death ctor: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be			s 2 □No					
≥	or At fter c direc n by	Ħ	4 Homicide determined 28e. Place of Injury - At he building, etc. (Specific	ome, farm, stre fy)	eet, factory, office	2	28f. Location (Str City or Town,	eet and Numbei State)	r or Rural	Route Numb	er.
	Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this certific tely filled in by the funeral director,					- 1					
	Hosp 4 hos Fune ely fi	edical	29a. Certifier (Check only one) (Check only one)	owledge, death	occurred at the time,	date and place, a	and due to the ca	use(s) and man	ner as sta	ted.	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	led	and mainer stated.								
	Not To	Σ	29b. Signature and title of certifier		29c. License n	umber	29	d. Date signed	(Month, D	lay, Year)	
,			MIS		D00	6 132	.	1/211	05		
			30. Name and address of person who completed cause of death (Item	n 23a) (Type, I							
			Semra Sahinci M D , 420 Ren	nsy1var	nia Ave., (Centrevi:	lle,Marv	land 21	617		
	Sta	te	31. Date filed (Month, Day, Year) JAN 2 6 2005 Registra Signa	ature	And .						
Ĺ	Registr	ar .	JAN & O CUUJ)	20 10	Marie						

	1.	For State Registrar	State of Maryla	•		of Health and I of Death		iene _{99. No.} 2005	0352
	1.	Decedent's Name (First, Middle, La	ist)				2. Date of Deat		3. Time of Death
ician		Michael Johnson	n				Month	Day Year	1807
dical	42	. Facility Name (If not institution, give			4h City T	Town, or Location of Deat		4c. County of Dea	th
niner	44	//	1 11	1-1	- 1	evenla		Prince	Geraois
	_		See 7. Age (In you	s. last birthday,			8. Date of Birth		thplace (State or Fore
al			1⊠M 2□F 73		Months	Days Hours Min.	(Month, Day,		thplace (State or Fore
or	_		1.	,			January	3,1934 was	shington,
	-	sual Residence of Decedent a. State 10b. County	10c. (City, Town or L	ocation.				10d. Inside City Limi
5		MD Prince (1X Yes 2□1
ct	_		Jeorges (Capitol				0- 0hi of Wh-+ 0	Lucia c2
Funeral Director	10	e. Street and Number			10f. Zip		'	0g. Citizen of What C	ourity?
<u>ee</u>		914 Kayak Ave.)743		USA	
ner	11	. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deced	ent of Hispanic Origin? (S ify Cuban, Mexican, Puer	specify Yes or No-	14. Race - Am Black, Whi	
교		1 Never Married 2 Married	1 to Yes 2 □No			No Specify:	, , , , , , , , , , , , , , , , , , , ,		
þ		3 ☐Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:		1 1 1 1 1 2	gy No Specify.		Specify: B	Lack
Completed by	1	15. Decedent's E	ducation	16a. Dece	edent's Usua	Occupation	dian	16b. Kind of Business	/Industry
<u>e</u>		(Specify only highest gr		life.	e kina of wor. DO NOT us	k done during most of wo e retired)	rking		
Ę		Elementary/Secondary (0-12)	College (1-4or 5+) 2yrs	E	lectri	cian		Priva	te
ပိ	17	7. Father's Name (First, Middle, Las.					me (First, Middle, I	Maiden Sumame)	
ae	4	Howard Johnson	,				,		
ုင	_	HOWARU JOHNISON			-	Amy Q			
	1:	9a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ling Address	(Street and Number or R	ural Route Number	, City or Town, State,	Zip Code)
	н	Renita Johnson,				Terrace, B			
	20	Da. Method of Disposition	206	. Place of Disp cemetery, cre	osition (Nam	ne of	Date	20c. Location - City of	Town, State
		1 Burial 2 Cremation 3	Hemovai from State			'1 Cem. 01/	/2//2005	Arlington	Virgini
	-	* 4 □ Donation 5 □ Other (Special						kins Funer	
9	2	Signature of Funeral Service Lice	insee	2-7.1					
а		PAD. your	horl			ndover Rd.,			55
	2	3a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the de	ath. Do not er	nter the mode	e of dying, such as cardia	c or respiratory arr	est,	Approximate Intervat Between
		mmediate Cause (Final							Onset and Death
in al		lisease or condition esulting in death)			100	ArdioVASCU	100 17 50	1 313 03	
er			Due to (or as a cons	equence or):		*			
	5	equantitally list conditions	b						
ue u	if	acuse (Disease or injury	Due to (or as a cons	equence or):					
Examiner	tt	iat initiated events	c						
ical Examin	re	esulting in death) Last	Due to (or as a cons	equence of):					
cian/Medical			d						
×	16	F FEMALE:	23c. If yes, outcome of preg	onancy				23d. Date of de	livery
	2	3b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ F	etal death 3	□Ectopic pr			Month	
10			4□Pregnant at time o	r death 5	Other (sp.				Day Year
sicia		1 ☐ Yes 2 ☐ No	9∐ Unknown			ecify)			Day Year
hysicia	-	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	Alexander III		ecity)			,
y Physicia	P			esulting in the			23e. Did to	bacco use contribute	to the cause of death
d by Physicia	P	9 Unknown		resulting in the					to the cause of death
eted by Physicia	P	9 Unknown		resulting in the			1 🗆 Y	es 2□No 3□F	o the cause of death
npleted by Physicia	P	9 Unknown		resulting in the			1 □ Y 24a. Whas a autop:	es 2 No 3 F	o the cause of death robably 4 Johnnutopsy findings avail
Completed by Physicia	P	9 Unknown		resulting in the			1 □ Y	es 2 No 3 F an 24b. Were a prior to death?	to the cause of death probably 4 Denkin utopsy findings avail completion of cause
e Completed by Physician/Med	2	9 Unknown art II. Other significant conditions 5. Was case referred to medical		resulting in the		ause given in Part I.	1 TY 24a. Was a autop: perfor	an 24b. Were a prior to death?	to the cause of death crobably 4 Denking autopsy findings availa completion of cause
Be	2	9 ☐ Unknown art II. Other significant conditions 5. Was case referred to medical examinar	contributing to death but not r		underlying c	ause given in Part I. 26. Place of De	1 Yas autop: perfor 1 Yes	an 24b. Were a prior to death? 22 No 1 Ve	o the cause of death robably 4 Denkhol utopsy findings availa completion of cause s 2 \(\sum \) No
To Be	2	9 Unknown art II. Other significant conditions 5. Was case referred to medical	contributing to death but not reconstributing to death but not rec	ER/Outpatie	underlying c	26. Place of De	1 Y 24a. Was a autop: perfor 1 Yes Path (Check only or Home 5 Resid	an 24b. Were a prior to death?	o the cause of death robably 4 Denkin utopsy findings avail completion of cause s 2 \(\sum \text{No} \)
To Be	2	9 Unknown art II. Other significant conditions 5. Was case referred to medical examinations 1. Per 2 No 7. Manner of Death 1. Naturat 5 Pending	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year,	ER/Outpatie	underlying co	26. Place of De Other: 4 \(\text{Nursing} \) Norker: 4 \(\text{Nursing} \)	1 Y 24a. Was a autop: perfor 1 Yes Path (Check only or Home 5 Resid	24b. Were a prior to death? 24b. No 3 F	o the cause of death robably 4 Denkin utopsy findings avail completion of cause s 2 \(\sum \text{No} \)
To Be	2	5. Was case referred to medical examples 2 No 1. Manner of Death 1. Naturat 5 Pending investigate	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	EE//Outpatie	underlying co	26. Place of De Other: 4 _ Nursing 18c. Injury at Work? 1 _ Yes 2 _ No	24a. Was a autoppender 1 Yes eath (Check only or Home 5 Resid	es 2 No 3 F an sy med? 24b. Were a sy prior to death? 1 Ye ne) ence 6 Other (Sp ow injury occurred	to the cause of death probably 4
To Be	2	9 Unknown art II. Other significant conditions 5. Was case referred to medical examinations 1. Per 2 No 7. Manner of Death 1. Naturat 5 Pending	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year,	ER/Outpatin 28b. Time Injury	underlying co	26. Place of De Other: 4 _ Nursing 18c. Injury at Work? 1 _ Yes 2 _ No	24a. Was a autoppender 1 Yes eath (Check only or Home 5 Resid	es 2 No 3 F an Sy med? 24b. Were a prior to death? 1 Ye ne) ence 6 Other (Sp ow injury occurred	to the cause of death probably 4
To Be	2	5 Was case referred to medical examinations 2 No 7. Mannes of Death 1. Naturat 5 Pending investigate 3 Suicide 6 Could not	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatin 28b. Time Injury	underlying co	26. Place of De Other: 4 _ Nursing 18c. Injury at Work? 1 _ Yes 2 _ No	24a. Was a autopiperfor 1 yes bath (Check only or Home 5 Resid 28d. Describe h	es 2 No 3 F an Sy med? 24b. Were a prior to death? 1 Ye ne) ence 6 Other (Sp ow injury occurred	to the cause of death probably 4
To Be	2	9 Unknown art II. Other significant conditions 5. Was case referred to medical examined and significant conditions 7. Manner of Death 1. Naturat 5 Pending investigath 3 Suicide 6 Could not determine	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year, on be did 28e. Place of Injury - A building, etc. (Spe	28b. Time Injury at home, farm, secify)	ent 3 DC of 2 M street, factory	26. Place of De Other: 4 Nursing 18c. Injury at Work? 1 Yes 2 No 7, office	24a. Was a autopperfor 1 Ves Path (Check only or Home 5 Resid 28d. Describe home 5 City or Tow	an sy y 2 No 3 F F F F F F F F F F F F F F F F F F	to the cause of death probably 4 Deficient utopsy findings avail completion of causes 2 No Pacify)
To Be	2	9 Unknown art II. Other significant conditions 5. Was case referred to medical examined and significant conditions 7. Manner of Death 1. Naturat 5 Pending investigath 3 Suicide 6 Could not determine	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year, de Duilding, etc. (Spe	28b. Time Injury at home, farm, secify)	ent 3 DC of 2 M street, factory	26. Place of De Other: 4 Nursing 18c. Injury at Work? 1 Yes 2 No 7, office	24a. Was a autopperfor 1 Ves Path (Check only or Home 5 Resid 28d. Describe home 5 City or Tow	an sy y 2 No 3 F F F F F F F F F F F F F F F F F F	to the cause of death probably 4 Deficient utopsy findings avail completion of causes 2 No Pacify)
Be	2	5. Was case referred to medical examinated and II. Other significant conditions 5. Was case referred to medical examinated and investigated a	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - A building, etc. (Spe	28b. Time Injury at home, farm, secify)	ent 3 DC of 2 M M street, factory	26. Place of De Other: 4 Nursing 18c. Injury at Work? 1 Yes 2 No 7, office	24a. Was a autopured of the coursed at the time. Called the coursed at the time.	an sy y 2 No 3 F F F F F F F F F F F F F F F F F F	to the cause of death probably 4 Denking utopsy findings avails completion of causes 2 No ecity) Bural Route Number, as stated, to the cause(s)
To Be	2	5. Was case referred to medical examinations 1. Yes 2 No 7. Manner of Death 1. Naturat 5 Pending investigate 2 Accident 3 Suicide 6 Could not determine	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - A building, etc. (Spe	28b. Time Injury at home, farm, secify)	ent 3 DC of 2 M M street, factory	26. Place of De 26. Place of De 26. Place of De 26. Place of De 27. Place of De 28. Injury at Work? 1 Yes 2 No 27. office at the time, date and place in my opinion, death occ License number	24a. Was a autopperformed at the time.	es 2 No 3 F an sy med? 24b. Were a sy med? 1 Ye ne) ence 6 Other (Sp ow injury occurred attreet and Number or F m, State) cause(s) and manner a date and place, and du	to the cause of death or obably 4 Defiking utopsy findings avails completion of cause is 2 No ecity) Bural Route Number, is stated.
To Be	2	5. Was case referred to medical examinated and II. Other significant conditions 5. Was case referred to medical examinated and investigated a	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - A building, etc. (Spe	28b. Time Injury at home, farm, secify)	ent 3 DC of 2 M M street, factory	26. Place of De 26. Place of De 26. Place of De 27. Other: 4 \sum Nursing 28. Injury at Work? 1 \sum Yes 2 \sum No 4, office at the time, date and place in my opinion, death occ	24a. Was a autopperformed at the time.	es 2 No 3 F an sy med? 24b. Were a sy med? 1 Ye ne) ence 6 Other (Sp ow injury occurred attreet and Number or F m, State) cause(s) and manner a date and place, and du	to the cause of death probably 4 Denkind utopsy findings avails completion of cause s 2 No point No po
To Be	2	5. Was case referred to medical examinated and II. Other significant conditions 5. Was case referred to medical examinated and investigated a	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - A building, etc. (Spe	28b. Time 28b. Time Injury Inthome, farm, s socity knowledge, dealination and/or in	ent 3 DC of 2 M street, factory ath occurred investigation	26. Place of De 26. Place of De 26. Place of De 26. Place of De 27. Place of De 28. Injury at Work? 1 Yes 2 No 27. office at the time, date and place in my opinion, death occ License number	24a. Was a autopperformed at the time.	es 2 No 3 F an sy med? 24b. Were a sy med? 1 Ye ne) ence 6 Other (Sp ow injury occurred attreet and Number or F m, State) cause(s) and manner a date and place, and du	to the cause of death probably 4 Denkin utopsy findings avail completion of causes 2 No ecity) Rural Route Number, as stated, e to the cause(s)

		•	For State Registrar	State of Ma		epartment of H Certificate of I			ene2005	03529	
			1. Decedent's Name (First, Middle, La	.st)				2. Date of Death Month	Day Year	3. Time of Death	
	Physicia /Medic		Phalam	John	Jordan	I]	I	January	20, 2005	1:56 p ^M	
	Examin		4a. Facility Name (If not institution, gir	re street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	ath	
	Laurel Regional Hospital Laure								George's		
	Funeral		,	Sex 7. Age 1⊠M 2□F	(In yrs. last birth	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign country)	
н	Director		214-36-2925	201	65 Yr	S.		Nov. 6,	1939 Was	shington, DC	
	and w		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town o	or Location				10d. Inside City Limits	
	sho	٥								1 ☐ Yes 2 ∑No	
	28a-f	Director	Maryland Montgo	mery	Silver	Spring 10f. Zip Code		10	g. Citizen of What C	tounter?	
	with a or							10			
	eath	Funeral	15104 Timberlake	12. Was Decedent E	ever in ITS		1905	ecify Vac or No-	U.S.		
	Item Item	5	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 🖾 N	0	 Was Decedent of History Cuba 	n, Mexican, Puerto	Rican, etc.)	Black, Wh		
38	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify: Will	nite	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Madical Exarcitmer reast be muffed at		15. Decedent's E			ecedent's Usual Occup		1	6b. Kind of Business		
7	n n	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5-		Give kind of work done o ife. DO NOT use retired	during most of work ()	ing			
21	d within giene. or than	mo:	12	Collogo (1 401 5		e Fighter			Montgome	ery County	
Þ	e filed il Hygie other vent, II	a)	17. Father's Name (First, Middle, Las.)			18. Mother's Name	e (First, Middle, M			
<u>a</u>	Aental Aental rked c	To B	Phalam John Jorda	ın			Mary Jane	e Nichols	son		
an	2 should be and Mental Is marked o		19a. Informant's Name/Relationship	Type, Print)	19b. N	Mailing Address (Street a	and Number or Rur	al Route Number,	City or Town, State,	Zip Code)	
	and 2 nalth n 27 I		Sondra Jordan / W	life	151	04 Timberla	ke Drive	, Silver	Spring, N	Maryland 2090	
ore	of He		20a. Method of Disposition	78	20b. Place of D	Disposition (Name of crematory or other place		Date 2	0c. Location - City o	r Town, State	
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If itam 27 is marked any injury or other traumatic esones.		1 ☐ Burial 2 ☑ Cremation 3 ['4 ☐ Donation 5 ☐ Other (Speci		1	coln Cremat	· .	4/2005 I	Brentwood	Maryland	
a E	permit. Departri Importa any inju		21. Signature of Euneral Service Lice	nsee	00	22. Name and Address	s of Facility HI	NES-RINAI	LDI FUNERA	AL HOME, INC.	
œ	Depar Impor any ir		Celan	1 Wan	well !	11800 New H	lampshire	Ave. Sil	lver Sprin	ng, MD 20904	
			23a. Part1. Enter the disease, or son shock, or heart failure. List only	plications that caused	the death. Do no	t enter the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between	
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition			Onset and Death					
			resulting in death)	a. Cirrhos Due to (or as a	Lousequence of)):					
Ю				b. Renal F			Years				
		Examiner	Sequentially list conditions, if any, leading to immediate	U	consequence of)):					
	cuted nd ransi		cause. Enter Underlying that initiated events	C	Due to (or as a consequence of):						
ó	an ar		resulting in death) Last								
68760,	ificate be executed g physician and as the burial-transit	edlcal		_ d							
	- 07 (0	Med	IF FEMALE:								
Вох	death certif e attending id for use a	an/l	23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth		3 □Ectopic pregnancy	topic pregnancy			Dav Year	
	O O	by Physician/M	sicia	in the past 12 months? 1 Yes 2 No	4☐ Pregnant at : 9☐ Unknown	time of death	5 Other (specify)			Month	Day Year
P.0	requires that the de een signed by the a hould be detached		9 Unknown					00. 51111			
Ś	6 5 6		by F	by	Part II. Other significant conditions	contributing to death bu	t not resulting in ti	he underlying cause give	en in Part I.		
ord	w requir been si should	ted						1 Yes	2 ⊠ No 3 □ P	robably 4 Unknown	
ec	S S D	ple						24a. Was an autopsy	prior to	utopsy findings available completion of cause of	
<u> </u>	Th ate	Completed						performe 1 ☐ Yes 2	formed? death?		
of Vital Record	Physician: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of Death	n (Check only one)		
Ž	S S S	2	1 ☐ Yes 2 🔀 No	Hospital: 1 X Inpatier	nt 2 EP/Outp	atient 3 DOA Othe	4 🗆 Nursing no		ce 6 □Other (Spe	ecify)	
	ng Ph	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Tin Year) Inju	ury Worl		28d. Describe how	vinjury occurred		
Division	Attending in death. actor: After by the fune	Certification;	2 Accident investigation			M 1 []	Yes 2□No				
Ξ	I or Att		3 Suicide 6 Could not to determined		ry - At home, farm . <i>(Specify)</i>	n, street, factory, office		 Location (Streetly or Town, 	treet and Number or Rural Route Number, n, State)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer										
	Hospital 24 hours a Funaral I	edical	(Check only 2 Medical Exa	miner: On the basis of	examination and/	death occurred at the tim or investigation, in my op	e, date and place, pinion, death occurr	and due to the cau ed at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)	
	To tha l within 2 To the l complet	Med	one)	and manner stat		29c. License					
	To To	-	29b. Signature and title of certifier	Red in	0			290	d. Date signed (Mon	ui, Day, rear)	
•	6		10 gu	7/()		D 500			anuary 20,	2005	
			30. Name and address of person who				t E. Sut	liff, III			
			8319 Cherry Lane,	Laurel, M	aryland	20707					
	Sta Registr	_	31. Date filed (Month, Day, Year) JAN 2 4 2	32 Registra	r's Signature	boarte					
	negisti	all	JAN 64 C	UUJ MANA	1 10 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** RUBY C, JENKINS 2005 January 22, 11:10 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Westminster
Under 1 Year | If Under 24 Hrs.
onths | Days | Hours | Min. 2641Baumgardner Road Carroll 8. Date of Birth (Month, Day, Year) 1/12/1919 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 □ F 220-12-9936 86 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location itam 27 is marked other than "netural", or itams 23e or 28e-f show other traumatic event, the Neutral Examination must be modified at 10a. State 10b. County Yes 2 No Director Carroll Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2641 Baumgardner Road 21158 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or itel any injury or other traumatic evant, the Medical Experiment ORG. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 20 No Specify: ρ 3√ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 8 Health Care Worker Hospital 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Delbert Lawrence Durst Manie Broadwater 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Terry Grimes/daughter 20a. Method of Disposition Westminster, MD 21158
Date 20c. Location - City or Town, State 3480 Flickinger Road, 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Grantsville Cemetery Jan. 27, 2005 Grantsville, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Newman Funeral Homes, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause op each line. 21536 Approximate Interval Between Onset and Death Immediate Cause (Final Why **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** P Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year detached for 5 Other (specify) 9 Unknown 9 Unknown been signed by 23e. Did tobacco use coptribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one, Other: 4 - Nursing Home 5 Residence 6 □Other (Specify) Certification: To 1 Yes 2 19 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 05 30. Name and address of person who completed cause of death (Item 23a) (Type/ Print) Dr. J. Margolis, MD, 31. Date filed (Month, Day, Year) 90 Painters Mill Road, Owings Mills, Maryland 21117 32. Redistrar's Signature State JAN 8 2 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					rtificate of	Death	R	eg. No. 20	05 0353			
	Dhusisian	Decedent's Name (First, Middle, Last					Dete of Deat Month	th	Year 3. Time of Death			
4	Physician /Medical	Allen Clintor	n Johnson				01	160	005 4.301			
	Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, or	Locetion of Death	4c. County of	f Death			
1		Chesapeake Woods	s Center			Cambrid	dge	Dor	chester			
	Funeral	5. Social Security Number 6. Se	7. Age (In y	rs. last birthday)	If Under 1 Yea Months Days			Year)	Birthplace (State or Foreign Country)			
	Director	217-10-8834 Usual Residence of Decedent	M 2□F 92	Yrs.	Months Day	Tiours Will.	Oct. 10	1912	Maryland			
	Maryland -f ehow feed at	10a. State 10b. County	10c.	City, Town or Lo					10d. Inside City Limits			
Ç		MD Dorchest	ter		Cambi				1 X Yes 2 □ No			
ζ	ufter death with the Marylar r frems 23e or 28e-f ehow niner must be notified at Funeral Director	10e. Street and Number 204 Meteor Ave.			10f. Zip Code	21613		0g. Citizen of W	Α.			
020	黄 岩 巴	11. Marital Status 11 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🕱 No	Hispanic Origin? (S ban, Mexican, Puert o Specify:	opecify Yes or No- to Rican, etc.)		- American Indian, , White, etc. white			
5-0	n 72 hours naturel', edical Exi	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual Occi	upation e during most of wor ed)	rking	16b. Kind of Bus	iness/Industry			
Baltimore, Maryland 21215-0020		Elementary/Secondary (0-12)	College (1-4or 5+)			nspector		shipy	ard			
D	ant, and	17. Father's Name (First, Middle, Last)		1			me (First, Middle, I					
au	Mental H Mental H arked off artic ever	Charles Goldsbor	rough Johnson	n		Lena	Ruark					
3	should Ministra	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailir	ng Address (Stree	et and Number or Ru	ural Route Number	; City or Town, S	State, Zip Code)			
ž	ith ar	Magdalene Mills	sister	1400	Glasgov	st., Car	mbridge,	MD 216	13			
ore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, ITE Mandes. To Be Compi	20a. Method of Disposition	Domoval from State	b. Place of Dispo cemetery, crer	sition (Name of natory or other pl	ace)	Date	20c. Location - C	City or Town, State			
Ë	Pag ment ant: i	4 ☐ Donation 5 ☐ Other (Specify)	Do			al Park						
Ball	Departing Departing Important Information	21. Signature Funeral Service Licens	eral Ho MD 21	me P.A. 613								
		23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
	Physician /Medical Examiner	Immediate Cause (Final disease or condition	disease		Onset and Death							
	ē la la	resulting in death)	Due to	o (or as a consec	quence of):							
	ntificate be axecuted ng physician and as the burial-transit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	bDue to	o (or as e conseq	uence of):	-						
68760,	ysiciar he buri	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
39 X												
Вох	attan for u											
o	the de shed	Part II. Other significant conditions co.	ntributing to death but not	resulting in the u	nderlying cause g	iven in Part I.		-	tribute to the cause of death			
s, P.O	s that the constant of the con						1 🗆 Y	s 2L⊬No :	3 Probably 4 ☐ Unknow			
of Vital Records,	The law raquiras that the death certificate be assecuted sate has been signed by the attanding physician and page 2 should be datached for usa as the burial-transi Completed by Physician/Medical Exami						24a. Was a perform	n autopsy ned?	24b. Were autopsy findings available prior to completion of cause of death?			
æ	hysician: The law nis certificate has to idirector, page 2 s						1Y	8 24NU	1 ☐ Yes 2 ☐ No			
ta	8 0	25. Was case referred to medical				26. Place of Dea	ath (Check only on	e)				
>	Physician: this certific ral director,	examiner?	Hospital: 1 ☐ Innatient 2	P FR/Outpatier	nt 3 DOA	thor:			r (Specify)			
o uc	<u>~</u> ≠ ₽	27. Manner of Death 1 ☑ Naturel 5 ☐ Pending		1 Inpatient 2 EH/Outpatient 3 DOA 4 Prursing Home					me 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred			
Division	To the Hospital or Attending Physician, within 24 hours after death. To the Funeral Director: After this certificonplataly filled in by the funeral director complataly filled in Expression Medical Certification: To Be	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
_	To the Hospital within 24 hours within 24 hours of To the Funeral complately filled		sician: To the best of my linar: On the basis of exam and manner stated.									
	ithin ithin on the one of th	ach Singal and Alle of and Vice	1 , ,		29c. Licer	nse number	2		(Month, Day, Yeer)			
	F≯Fŏ) Deur	lung MO		D	47924		1-19	-05			
		30. Name and address of person who co	ompleted cause of death (I	Item 23e) (Type,	Print)	CAMAR	IDGE 1	40 2	1613			
	Ctoto	31. Date filed (Month, Day, Year)	2005 32. Redistrar's Signature.									
	State Registrar	JAN 2 1	2005	. J. 16	perse							

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Yeer Month **Physician** JANUARY 9, 10:20 PM 2005 CAROLYNN LOUISE KRAFT /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Hours 1 M 2 X F 80 JULY 19, MARYLAND Director 219-18-7427 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City. Town or Location rel', or iteme 23s or 28s-f show Examiner mest be notified at 1 ☐ Yes 2 XNo ANNAPOLIS ANNE ARUNDEL MD Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 930 BAY FOREST COURT 21403 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ▼ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: If item 27 te marked other than "naturel", or ite 1 Never Married 2 Married WHITE 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: ð 3 ₩Widowed 4 Divorced Completed or than "natur 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 11 HOMEMAKER of Health and Mental Hygi If Item 27 ie marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ELEANOR DELORES JEFFRIES EDWIN THEODORE MIEGEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1920 SEVERN GROVE RD., ANNAPOLIS, MD BARBARA MCCORD/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it eny injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY | 01/12/2005 STEVENSVILLE, MD 21. Signature of Funeral Service Ligense ADAMS FUNERAL & CREMATION CARE, 814 BESTGATE RD. ANNAPOLIS, MD 21401 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 2 DAYS SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed use-as the burial-transit and resulting in death) Last Due to (or as a consequence of) Box 68760 nding physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) should be detached Division of Vital Records, P.O. 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe Completed by 1 Yes 2 No 3 Probably 4 Unknown COPD, PERIPHERAL VASCULAR DISEASE, ABDOMINAL AORTIC 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ANEURYSM, OSTEOPOROSIS, CHRONIC BACK PAIN 2 X No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 EN/Outpatient 3 DOA 1 ☐ Yes 2 X No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? al or Attending P after death. I Director: After t d in by the funera 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 🗌 Homicide within 24 hours a To the Funeral L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manger stated. 29d. Date signed (Month, Day, Year) 29c. License number 296. Signature and title of certifier 1-11-05 D0035235 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2002 MEDICAL PARKWAY, ANNAPOLIS, MD 21401 DAVID E. MATTESON, M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 1 4 2005

Blown & Sporte

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 2005

December here First Mode, Last Section December here first Mode, Last December here first M		1 - For State Registrar	, , , , , , , ,	Cer	tificate of L	Death	R	eg. No.	00000
Suppose Suppose Suppose and matter the country of t						-	2. Date of Deat	th	3. Time of Death
Suburian Management of Service Service and numbers Sc. Cyt. Town or Location of Death Monts gomery Signature Service Service Ser	ysician	Buyong	Kuk	Ki	m				1:36PM M
Suburban Hospital Special Service Number Special Service Service of Photosection Special Service Service Special Service Servi	aminer		reet and number)			Location of Deat			
399 38 6922 NAME COLORS NO. 1924 NOTES 1000 VIta More Street Name (1924) Secretary 1924		Suburban Hospital			Betheso	da		Montgome	erv
399 38 6922 1	eral							Year) 9. Bir	
Top. State Top. Colors T		399 38 6922	80	Yrs.	Widness Buyo	110010			**
Nary Land Montgomery Potomac 106, 2016 and whose of whose place 106, 2016 and whose of whose place 106, 2016 and whose of whose place 106, 2016 and whose 106, 2016 and whose place 106, 2016 and whose 106, 2016 and whose place 106, 2016 and whose 106, 2016 and whose place 106, 2016 an			10c. City	y, Town or Lo	cation				10d. Inside City Limits
Summaries Summ	ţo	Maryland Montgome	ry Po	tomac					1 ☐ Yes Z No
13313 Sunny Brooke Place 12 Was Dependent Fever in U.S. 13 Was Dependent Fever in U.S. 13 Was Dependent Supplied Fever in U.S. 14 Was Dependent Supplied Fever in U.S. 15 Was Dependent Su	i e			LUMBIL	10f. Zip Code		1	0g. Citizen of What Co	ountry?
Martal Status 12 Martal		13313 Sunny Brooke	Place		208	54		USA	
Specify Asiam Asiam Specify Asiam Sp	ner		2. Was Decedent Ever in U.	S. 13. V			pecify Yes or No-		
Specific Continued Specifi			1 ☐ Yes 2 ★★o	- 1			, , , , , , , , , , , , , , , , , , , ,		
Jung Sik Kim Son Kim				(Give)	kind of work done a	furing most of wor	rking		
Second Comparison Seco	ig m	Elementary/Secondary (0-12)	, ,			•		Sogang Uni	iversity
Single Six Kim Son Six Kim 19a. Informants Name/Balabachip (Type, Print) 19b. Mailing Address (Street and Number of Plural Boute Number, City or Town, State, Zip Code) 7908 Lakenheath Way Potomac, Maryland 20854 20c. Location - City or Town, State 20c. Description - City or Town, State 20c. Place of Dispassion (Number of Plural Boute Number, City or Town, State 20c. Description - City or Town, State 20c. Place of Dispassion (Number of Plural Boute Number, City or Town, State 20c. Description - City or Town, State 20c. Description - City or Town, State 20c. Place of Dispassion (Number of Plural Boute Number) 20c. Place of Dispassion (Number of Plural Boute Number) 20c. Place of Dispassion (Number of Plural Boute Number) 20c. Place of Dispassion (Number of Plural Boute Number) 20c. Place of Dispassion (Number of Plural Boute Number) 20c. Place of Dispassion (Number) 20c. Place of		17. Father's Name (First, Middle, Last)	5 1	2002	01 300101		me (First, Middle, M		LVCIBLEY
198		Jung Sik Kim				Pan S	oon Kim		
20. Method of Disposition Comparison Com		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (Street a	and Number or Ru	ıral Route Number,	, City or Town, State,	Zip Code)
SZBourial x Coremation 3 Removal from State Cate of Hazven Cometery 1/32/05 Silver Spring, Marylat Alexandros of Facility Hines Rinaldi Funeral Home 22. Name and Address of Facility Hines Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring, MD 2090.		Yang Kim / Son		7908	Lakenheat	th Way Po	otomac,Ma	ryland 208	354
2/5 Part Erien the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate class First Control of the cause of the ca	-	· ·		lace of Disposemetery, crem	sition (Name of natory or other place	θ)	Date	20c. Location - City or	Town, State
25 Part Liver rise sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate course from the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate course from the sease, or complications that caused the death. Approximate course from the sease of the sease				e of H	eaven Cen	netery 1	/22/05 5	Silver Spri	ino. Marvlan
25 Part Ligher the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate condition or condition		21. Signature of Funeral/Service License		22	. Name and Addres	s of Facility H1	nes Rinal	di Funeral	Home
Sapert Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increase Approximate Appro		Towns &	lusu-						
Part Onset and Death Ons		2.a. Part1. En er the disease, or complic	ations that caused the death						Approximate
auto. Enter Underlying that initiated events. Enter Underlying that initiated events and events and events. Enter Underlying that initiated events and events and events. Enter Underlying that initiated events and events and events and events. Enter Underlying that initiated events and events and even		Imm lists Cause (Final		1111111	My	1112	,—		Onset and Death
The state of the			Due to (or as a consequ	neuce ot).	0,70	prerior s			
Temporary Temp			ENMA (A	mon	Home	UNITAR	- "		
FEMALE: 23b. Was decedent pregnant: 1	ē	Sequentially list conditions, b. if any, leading to immediate	Dua to (or as a consequ	derice of).	- 1/0.				-
FEMALE: 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery Month Day Year 1 Year 2 No 3 Probably 4 Microway	E	Cause (Disease or injury							
23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 1 23c. If yes outcome of pregnancy 23c. If yes outcome of pregnancy 1 23c. If yes outcome of pregnancy 23c. If yes outcom	Exa	resulting in death) Last	Due to (or as a consequ	uence of):					
23b. Was adecadent pregnant in the past 12 months? 1		d.						_	
23b. Was decedent pregnant in the past 12 months?	ed					-			
1 Yes 2 No 3 Probably 4	-	93	1						
1 Yes 2 No 3 Probably 4	icia		Month						
25. Was case referred to medical examiner? 1 Yes 2 No 3 Probably 4 Warknown 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Warknown 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 1 Yes 2 No 3 Probably 4 Warknown 26. Place of Death (Check only one) 27. Mann Death Sheating Death Sh	hys								
24a. Was an autopsy performed? 24a. Was an autopsy performed? 24b. Were autopsy findings available performed? 25. Was case referred to medical examiner? 1 yes 2 yes 2 yes 1 y		Part II. Other significant conditions cont	pacco use contribute to	co use contribute to the cause of death?					
25. Was case referred to medical examiner? 1							1 🗌 Ye	es 2 No 3 P	obably 4 Mknown
25. Was case referred to medical examiner?	olet								utopsy findings available
25. Was case referred to medical examiner? Solution Solution	I E						perform	ned? death?	·
examiner? 1 Yes 2 No	O	25 Was case retarred to medical				26 Place of Dec			2 110
27. Mann f Death 1 fatural 2 Accident 1 fatural 2 Accident 3 Suicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Month, Day Year) 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? M 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier Check only one) 29a. Certifier Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and dadress of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date Signed (Month, Day,	m	examiner?	ospital:	ER/Outpations	Othe				cifu)
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and dadress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. Certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1		28a. Date of Injury	28b. Time of					city/
29a. Certifier (Check only one) 29m Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 70 55 2 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	ţ	1 ⊟Natural 5 □ Pending (Month, Day Year) Injury Work? M 1 □ Yes 2 □ No							
29a. Certifier (Check only onle) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEO CONTROL SUMMEN 100 CONTROL SUMMEN 1	fica	3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, farm, stre	eet, factory, office		28f. Location (Str	reet and Number or Ri	ural Route Number,
29a. Certifier (Check only one) 29medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30c. Name and address of person who completed cause of death (Item 23a) (Type, Print)	erti	4 Homicide	building, etc. (Specify	1)			City or Town	i, State)	
29b. Signature and title of certifier 29c. License number 170 55 2 29d. Date signed (Month, Day, Year) 700 55 2 700 700 700 700 700 700 700 700 700 70									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LED C. NOTTO SUBUST / LISPAM BITISDA NO	Medi	one)	and manner stated.						
OA Dear Mark Mark Dear Mar		250. Signature and title of certifier	Min "	KN					
On Date Class (March 1997) No. 1 On March 1997 Of the Control of t		1-100			1 10	155		Muchy	19 2005
not Det. (Heat (March Dec. March Dec. March Dec. March Dec. March Dec. Dec. Dec. Dec. Dec. Dec. Dec. Dec.				23a) (Type, F	Print) URWB1	n 16	CHM	Sinn	DA NO
	State	31. Date filod (Month, Day, Year)		ture /	-03	1			

			1100	State of M	ondon	d / Done	artment of H	loolth a	and Me	ntal Hye	riono	egibic.		
			For State	State of M	arylan		rtificate of L				- 2	005	03531	
			State Registrar 1. Decedent's Name (First, Middle	a donath			lineale of L	Dealli		P. Date of Dea	Reg. No:≖	000	3. Time of Death	_
	Physicia	an	Derothy	J. Last)		King				Month	Day	Year	10:30 PM	
	/Medic	al		E (ring	4b. City, Town, or	Location		Jan	19	2005 ounty of Deat		_
	Examin	er	4a. Facility Name (If not institution				•		or Deam			-		
			Shady Grove Ad 5. Social Security Number			last birthday)	Rockv	If Under	24 Hrs. 8	B. Date of Birtl		ntgome	hplace (State or Foreign	-
	Funeral Director		213 42 8008	1□M 2 X F	60	Yrs.	Months Days	Hours	Min.	B. Date of Birtle (Month, Day May 30	7 (Year)	. Co	aryland	
		1	Usual Residence of Decedent						· · · · · ·	,				
	ylan		10a. State 10b. County			y, Town or Lo							10d. Inside City Limits	
	a-f s	io	Md. Mont	gomery	G	aither	sburg						1 XYes 2 No	
	or 28	Funeral Director	10e. Street and Number				10f. Zip Code					en of What Co		
	23a	aic	439 N. Frederi	ck Avenue, (C-3			2087				ted St		
	r deg	nue	11. Marital Status	12. Was Decedent Armed Forces?	,	.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Ori in, Mexicar	igin? (Spec n, Puerto Ri	ify Yes or No- ican, etc.)	. 14	 Race - Ame Black, White 		
ဂ္ဂ	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	If Vas Give	No		1 ☐ Yes 2 No	Specify:			S	Specify:	White	
3-003p	filed within 72 hours after death with the Maryland Hybjene. the than "natural", or Itams 23a or 28a-f show ant, the Madical Examinating Condiffed at			it's Education		16a Decer	dent's Usual Occupa	ation			16h Kind	d of Business/	Industry	_
ņ	n 72	jet	(Specify only highe	st grade completed)		(Give	kind of work done of DO NOT use retired	during mos	it of working	7	TOD. TUIT	or Duomicou	dddi,	
7	with iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	1	sser				Drv	Clean	ina	
0	Hygi Hygi other snt,	ပိ	17. Father's Name (First, Middle,					18. Mothe	er's Name (First, Middle,				_
yland	id be ental ked c	To Be	Orin King					I	da I	Howard				
Ξ.	shound M	-	19a. Informant's Name/Relations	thip (Type, Print)		19b. Mailir	ng Address (Street a	and Numbe	er or Rural	Route Numbe	r, City or	Town, State, Z	Zip Code)	
Z	nd 2 alth a 27 is		William King /	Brother		2182	O Clarkst	ourg 1	Road,	Boyds	, Mar	yland	20841	
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23a or 28a-f show any portant: If item 27 is marked other than "natural; or Itams and Itams or 23a or 28a-f show any intry or other traumatic event, the Madical Examinat must be notified at once.		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of natory or other plac	(e)	Da	te	20c. Loca	ation - City or	Town, State	
saitimore,	Page ient c nt: If ry or		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		, 1		s Cemeter		1/24	/05	Germ	antown	, Md.	
<u>=</u>	mit. partmoorta		21. Signature of Funeral Service	Licensee		22	Name and Addres				Ната			
ñ	Person		Muriel	H. Barbe	1/		Name and Address Muriel H. P. O. Bo	x 50.	38, L	ytons	ville	, Md.	20882	
	0 - 34 1		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	d the deat	h. Do not ent	er the mode of dyin	ng, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Hetasi		Fn	dometrio	31	Can	cer		9	Onset and Death 2 days	
	/Medical		resulting in death)	Due to (or as			70.777.67.						- 609/	
	Examiner		Convention line conditions	b										
	B =	ner	if any, leading to immediate Due to (or as a consequence of):											
	ocute nd trans	Examiner	that initiated events	use (Disease or Injury at initiated events c.									_	
, 00,	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):											
	certificate be executed adding physician and use as the buriat-transit	licai		d										
P P X	leath certificat attending phy I for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	of progn	2201								Ì
ŏ n	ath tter or u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Feta	Ideath 3[Ectopic pregnancy Other (specify)	1			23	3d. Date of del Month	Day Year	
o.	0 0 0	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	II WITE OF C	eatt 5								
7	requires that the der een signed by the a hould be detached f	H.	Part II. Other significant conditi	ons contributing to death	but not res	ulting in the u	nderlying cause give	en in Part I	1.	23e. Did to	obacco us	e contribute to	the cause of death?	
g S	sign d be	d by								1 🗀 Y	res 2 🗆	No 3□Pr	obably 4 @Unknown	
COL	~ D /A	Completed								24a. Was	an	24h Ware au	stopsy findings available	
ř	has has	mp								autop		prior to death?	completion of cause of	
	ician: Th certificate rector, pag		OF Was seen referred to medical						- 4 D 45	1 Yes		1 🗆 Yes	2 No	_
VITal		o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🖾 Inpati	iont 2	ER/Outpatier	Oth			Check only o		□Other (Spe	0.16.1	
ō	Phys r this aral di	F .	27. Manner of Death	28a. Date of Injury		28b. Time o				d. Describe h			Chy)	
0	ding Ith. Th. After Ither	tior	1. ☑ Natural 5 ☐ Pendii 2 ☐ Accident invest	ng (Month, Da igation	ay Year)	Injury		k? Yes 2.□	No No					
DIVISION	il or Attending after death. I Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of In	jury - At h	ome, farm, sti	reet, factory, office		28	28f. Location (Street and Number or Rural Route Number,				Ť
\leq	i di ti	ert	4 Homicide determined determined building, etc. (Specify)						City or Tow	or Town, State)				
	the Hospital or hin 24 hours afte the Funeral Dir npletely filled in			ng Physicien: To the best										
	n 24 n 24 he Fu	Medical	(Check only 2 Medical one)	Examiner: On the basis of and manner s	tated.	ation and/or in	vestigation, in my o	pinion, dea	atn occurred	at the time, o	date and p	olace, and due	to the cause(s)	
	To the Hospital within 24 hours a To the Funeral Completely filled	Σ	29b. Signature and title of certific	1 1		MIS	29c. Licens		9			signed (Monta	1,000	
	4		Chushie	lepontre		///	6/	7	/		Jan	20 +4	200-	
			30. Name and address of person			n 23a) (Type,	Print)	L CEM	תבט ט	D DO	CKALI	IE MD	20850	
			Christine	Lepout	e Sinc	990	1 MEDICA	L CEN	ILEK D	N., KU	ONVIL	LL, III	. 20030	_
	Sta Registi	-	31. Date filed (Month, Day, Year	2005 32 pagist	iai a aigili	B A	arts.							
			41044	LIE REL	,	- /								

State of Maryland / Department of Health and Mental Hygien 03535 1 - For State Registrat Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 08:02 a^M January 2005 WANDA KLIMCZUK /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Montgomery Casey House Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1 M 2 4 Yrs. Poland Director 11. 363-44-9458 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County in than "natural", or Items 23s or 28e-f show the Medical Examinant must be notified at 1 ☐ Yes 2 No ō VA Fairfax Great Falls Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22066 9801 Georgetown Pike USA within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Compl and Mental Hyglene. Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked oth any njury or other treumatic event SDE. Helen Hlebko Romuald Kotowicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9801 Georgetown Pike Great Falls, VA Stephen J. Klimczuk - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 02/01/2005 Herndon, VA Adams-Green F.H. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams-Green Funeral Home 721 Elden St., Herndon, mm 23a. Part1. Enter the diseas part complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YEARS Physician DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PARKINSON'S DISEASE YEARS Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of nding physiclen and use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Year Day 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Cerebro Vascular Accident - Multiple Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate 1 ☐ Yes 2 No Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 은 1 🗌 Yes 2 **X**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) After thi funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Hospital or Attending 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation hours after death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 Homicide filled in t within 24 hours 2 To the Funerel ! To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 BR4216114 January 31, 2005 30. Name and address of perion o impleted cause of death (Item 23a) (Type, Print) 9715 Medical Center Dr., #221 MD Rockville, MD 20850 Chitra Rajagolpal, 32. gistrar's Signature 31. Date filed (Month, Day, Year) State 0 Beson & Sparle Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. |

Records,

Division of Vital

DHMH 17 Rev 1/2001

Registrar

FFB 07

2005

		•	1 - For State Registrar	State of Ma		epartmer Certificat			and M		giene Reg. No.	2005	i	537
	Physici		Decedent's Name (First, Middle Vada Locke			-				2. Date of De. Month Januar	Day	Yeer 2005	3. Time of 9:40	Death D
	/Medic Examin		4a. Facility Name (If not institution			4b. City,	Town, or	Location of	of Death			County of Deeth	,	
		-	Washington Adv				oma P	Park	24 Hrs			ntgomery		
ı	Funeral Director		5. Social Security Number 431-01-1141	1 TM 257 E	e (In yrs. last birt 89	rs. Months		Hours	Min.	8. Date of Bird (Month, Da May 7	y, Year)	Cou	place (State ontry)	_
			Usuel Residence of Decedent				1			ridy / 3	1713			
	how		10a. State 10b. County		10c. City, Town	or Location							10d. Inside Ci	ity Limits 2 ☐ No
	Ba-f e	Director		Georges	Adelph		2.1				10a China	an of Mhat Cau		
	with the	Dire	10e. Street and Number	D I			0783					en of What Cou JSA	nuy r	
	eath	era	1801 Metzerott	12. Was Decedent I	Ever in U.S.			ispanic Ori	gin? (Spe	city Yes or No Rican, etc.)		4. Race - Amer		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if them 27 is merked other than "natural", or tems 23a or 28a-f show any injury or other traumatic event, the Medical Examinant must be notified a once.	by Funeral I	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	Armed Forces?		If Yes, spe		n, Mexicar Specify:		Rican, etc.)		Black, White Specify:	etc.	
21215-0036	2 hou atura	Completed by	15. Decedent	's Education	16a.	Decedent's Usu (Give kind of wo	al Occupa	ation	t of worki	200	16b. Kind	d of Business/Ir		
215	thin 7 8.	pie	(Specify only highes Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT u	se retired))	(OF WORKII	ng .				
7	filed will Hygien ther th	Con		4		· · · · · · · · · · · · · · · · · · ·	Nur		d- 81	(Final Adiately		lical_		
and and	be fit stal H bd ott	Be	17. Father's Name (First, Middle, I	_ast)						(First, Middle,	Maiden S	oumame)		
Maryland	should be nd Mental marked o	7	James Cowan 19a. Informant's Name/Relationsh	nin (Tyne Print)	19b	Mailing Address	s (Street a		COW 8		er. City or	Town, State, Zi	o Code)	
<u>S</u>	od 2 sho		Lemuel L. World			45 S. N								
	s 1 and I Health Itam 27 other tr	Ì	20a. Method of Disposition	Бүнсрисм	20b. Place of	Disposition (Na	me of			ate		ation - City or T		
OE .	Pages nent of I int: If It		1 Burial 2 Cremation 4 Donation 5 Other (St			ood Pk			Jan.2	29.2005	Incle	mond. I		
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service		1/	22. Name a	nd Addres	s of Facilit	y John	nson &	Jenki	ins Fun	eral Ho	ome
m	perm Depa Impo any ii		Depuo	-Chaper	99-	716 Ke	nnedy	v St.	NW I	Washing	ton.	DC 200		
4. 44			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lir	the death. Do n	ot enter the mod	de of dying	g, such as	cardiac o	r respiratory ai	rrest,		Approximat Interval Bet Onset and I	ween
	Physician		Immediate Cause (Final disease or condition	CARDI	AC AR	RYTH	MV	15					011301 0113 1	
К	/Medical Examiner		resulting in death)	Due to (or as	a consequence of); 24 C		. 0	ΔΠ	620 6	2			
3	E	-	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	b. ON G	a consequence of	2 1 12+	1061	+1		_ 010	,			
	nsit	Examiner	Cause (Disease or injury	6 GLOBA	IFF	T VENT	7100	(A.i.	De	15 FUI	YOT	-100		
,	te be executed ysician and e burial-transit	Exa	that initiated events resulting in death) Last		a consequence o		10,00	/		~ (00			
760,	, × e	cal		Ca CORI	AMC	W.	AR	TES	LY	1018	由力	51		
9	eath certificat attending phy I for use as the	Medi	IF FEMALE:			1								
Вох	ath ce ttendi or use	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic p					23	3d. Date of delive Month	-	Year
0	The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as th	Physician/M	1 Yes 2 No	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 Other (s)	secify)							
<u>.</u>	that the de led by the a detached t	Ph	Part II. Other significant condition	ons a milibuting to death by	at not resulting in	the underlying	causa give	en in Part I		23e. Did to	obacco use	e contribute to	the cause of c	death?
ds,	uires tha signed id be del	d by	DSEPS15.	2 MET,	A130 L	IC AC	1100	815	4	101	Yes 2.1☑	No 3□Pro	bably 4 🗍	Jnknown
Records,	w require s been si should b	Completed	a) SEVERE	ELECTRA	DLYTE	's Dis	IN	43/3	NCF	24a. Was		24b. Were aut	opsy findings	available
æ	The tay te has age 2:	mo	AMOSEC	15 EBN	16000	OLIT	15.			autor perfo	rmed?	death?	ompletion of c	ause or
	ilcian: The certificate rector, pag	0	25. as case referred to medical				1/	26. Place	of Death	(Check only o				
	Physician: r this certific ral director,	To B	examiner? 1 Tes 2 No	Hospital: 1 V npatie	nt 2 ER/Out	patient 3 De	OA Othe	er: 4 🗆 Nu	rsing Ho	me 5□ Resid	dence 6	Other (Speci	fy)	
ב	ding P		27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	28a. Date of Injury (Month, Day	y Year) 28b. T		28c. Injury Work			28d. Describe I	how injury	occurred		
Sio	Attending or death. actor: After by the fune	icati	2 Accident Investig	not be	ini. At homo foi	M street feater		Yes 2	_	28f Location /	Street and	Number or Rui	al Route Num	her
Division of	I or Attendated after death Diractor:	Certification;	4 Homicide determ	ined 28e. Place of Inju- building, etc	c. (Specify)	im, street, ractor	y, onice			City or Tov		rvamoor or ries	a, , , , , , , , , , , , , , , , , , ,	501,
	To the Hospital or Attending Physician: The Whin 24 hours after death. To the Funeral Diractor: After this certificate his completely filled in by the funeral director, page	edical C	(Check only 2 Medical	g Physician: To the best of Examiner: On the basis of	examination and									3)
	thin 2 thin 2 the	Med	one) 29b. Signature and title of certifier	and manner sta	M W	V/Q1/29	c. License	e number			29d. Date	signed (Month	Dey, Year)	
	F 3 F 8		MONONY	med 11.		MA	Da	245	9	5	1	.19	DOD.	05
	18/		30. Name and address of person.	who_completed.cause of d	eath (I) 670 23a) v	Type, Print	-a	32	1 -	101	PI	2001	511	GACA
			31. Date filed (Month, Day, Year)	MAIN , A (ar's Signature	MY).)]	IYA.	TTS	VILL	B	M	7, 20	782
	Sta Registr		JAN 2 5 2005	Bean W	Soule									

			For State	State of M	Maryland / Depa	artment of H	ealth and M			03538
			1. Decedent's Name (First, Middle,	Last)		timouto or E	Journ	2. Date of Death	g. No.	3. Time of Death
	Physici		Malvina B. Prei	,				Month	Day Year 21, 2005	
	/Medio Examir		4a. Facility Name (If not institution,		r)	4b. City, Town, or	Location of Death	January	4c. County of Deat	
	LXuiiii		Holy Cross Host	vital		Silver S	Spring		Montgome	
	Funeral			S. Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,)	9. Birt	hplace (State or Foreign
Н	Director		350-20-2744	1□ M 2 🙀 F	78 Yrs.	Months Days	Hours Min.	Jan. 20, 19		nois
	p ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo					
	anyla	'n	Toa. State		Toc. City, Town of Et	cation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ne M	Funeral Director	Maryland Montg	gomery	Silver	Spring				
	with t	ā				10f. Zip Code		100	g. Citizen of What Co	untry?
	s 23	era	10009 Greeley A	12. Was Deceden	t Ever in II S 12	2090		oify Van or No	USA 14. Race - Ame	rican Indian
	ter d	'n	1 Never Married 2 Marrie	Armed Forces	? ! No	Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, White	
336	urs af	by	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□ Yes 2√2 No	Specify:		Specify:	n_ 4 + _
ğ	72 hours after death with the Maryland Instural, or Items 23a or 28a-1 show Jigal Exantine must be notified at	ted	15. Decedent's			ent's Usual Occupa		16	Bb. Kind of Business/	<u>hite</u> Industry
215	hin 7 9.	ple	(Specify only highest Elementary/Secondary (0-12)	Grade completed) College (1-4or	life.	kind of work done d DO NOT use retired)	luring most of worki)	ng		
2	giene giene er tha	Completed		4		emaker			Own Home	
g	al Hy d oth	Be (17. Father's Name (First, Middle, La	ist)			18. Mother's Name	(First, Middle, Ma	iden Sumame)	
<u>yla</u>	Ment Ment Brice atice	To	Joseph Bartos	iewicz			Mae (Czaplicki		
Maryland 21215-0036	2 sho and ls ma		19a. Informant's Name/Relationship	о (Туре, Print) Daugh	19b. Mailir	ng Address (Street a			City or Town, State, Z	(ip Code)
	and ealth n 27		Elizabeth Marie	Magill Magil	4001	Tweedsmui			irginia	
ore	L S S S S		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Removal from State	20b. Place of Dispo cemetery, crer	natory or other place		ate 20	c. Location - City or	Town, State
Ē	Pag ment ant: ury		'4 □Donation 5 □ Other (Spe		Gate of H	eaven Cemeterv	Jan. 2	4,2005 S	ilver Spri	ing. MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show eny Injury or other traumatic event, the Modeal Experiment must be notified at once.		21. Signature of Funeral Service Lic	ensee		Name and Address	s of Facility		lome, Inc.	
ш_	20 E 2 9		23a. Part Enter the disease, or co	, Madah	50	O Univers	ity Blvd		er Spring	MD 20901
			23a. Part Enter the disease, or co shock, or heart failure. List or	mplications that cause by one cause on each	ed the death. Do not ent line.	er the mode of dying	, such as cardiac o	r respiratory arrest	t.	IIIIGIATI DO(MOCII
	Physician		Immediate Cause (Final disease or condition	_a. Pneumo	nia					Onset and Death
	/Medical Examiner		resulting in death)		s a consequence of):					i-sin/A
ı	Lammer	_	Sequentially list conditions,	b. Myocar	dial Infarc	tion				
	Sit 9d	lne	Sequentially list conditions, if any, leading to immediate	Jue to (or as	s a consequence of):					
	ecute and tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		Fibrillati s a consequence of):	on				
8760,	ate be executed hysician and the burial-transit	E E				on activities	15-2-20-0			
87	rcate be executed physician and s the burial-transit	dical		d. Chront	c Obstructi	Ve Pulmon	ary Disa	lac .		
9 ×	death certifica e attending ph id for use as t	Physician/Me	IF FEMALE:	23c. If yes, outcome	e of pregnancy				004 Date of della	
Вох	atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delin	very Day Year
o.		ysle	1 □ Yes 2 🏝 No 9 □ Unknown	9□ Unknown	It will by death 5	Cities (specify)				
<u>α</u>	The law requires that the de ate has been signed by the a page 2 should be detached	P	Part II. Other significant conditions	s contributing to death	but not resulting in the u	nderlying cause give	n in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
Records,	uires sigr	d by	Acute Renal	Failure				1√ Yes	2 No 3 Pro	bably 4 Unknown
00	w requ	Completed	Consis					24a. Was an	24h Were aut	topsy findings available
Re	The law cate has page 2 s	ф	Sepsis					autopsy	d? prior to o death?	ompletion of cause of
ā	ician: Th certificate rector, pag		25. Was case referred to medical				00 81/ 8		No 1 ☐ Yes	2½ No
5	Physician: r this certifica ral director, p	o Be	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ent 2 ER/Outpatien		26. Place of Death		e 6 □Other (Spec	
Division of Vital		\vdash	27. Manner of Death	28a. Date of Inju			at 2	8d. Describe how		ny)
on	ttanding F death. stor: After the funera	ţ	1 X Natural 5 ☐ Pending 2 ☐ Accident investigat		a <i>y Year)</i> Injury		? 'es 2 🗆 No			
NIS.	I or Attandi after death Diractor: A I in by the fu	ifica	3 Suicide 6 Could not	28e. Place of in	jury - At home, farm, stre	eet, factory, office	2		et and Number or Rui	ral Route Number,
Ö	al or A s after il Dira	Certification;	4 Homicide	bullding, e	tc. (Specify)			City or Town, S	orare)	
	To the Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the tune		29a. Certifier 1 Certifying	Physicien: To the best	of my knowledge, death	occurred at the time	e, date and place, a	nd due to the caus	se(s) and manner as	stated.
	n 24 ha Fu bletel	Medical	(Check only 2 Medical Ex	aminer: On the basis of and manner st	of examination and/or invitated.	estigation, in my opi	inion, death occurre	d at the time, date	and place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	140.0:10		29c. License	number		Date signed (Month,	The state of the s
•	6		1	MAMIM		7 5928	4		01/21/2	5007
	Ψ		30. Name and address of person wh	o completed cause of	death (Item 23a) (Type,					
_			Shahid Shamim,	M.D., 129	9 Lamberton	Drive, S	ilver Spr	ring, MD	20902	
	Sta		31. Date filed (Month, Day, Year)	32 Regist	rar's Signature	rete 3				
	Registra	ar	JAN 24	TUUD CUUL	as so popular					

			1 - For State Registrar	State of	Marylan		artment rtificate			ınd M	,	giene	200	15 0	250/
>	Physici /Medic Examir	cal	Decedent's Name (First, Middle, La Gloria 4a. Facility Name (If not institution, give			Rae	4b. City, 1	Town, or	Location o	f Death	2. Date of De Month Jan	Day 12	Yea 200 County of D	5 2:3	e'of Death
	Funeral Director		Holy Cross Hosp: 5. Social Security Number 5.79-34-6755		Age (In yrs. I	ast birthday) Yrs.	Si] If Under Months		Spri If Under 2 Hours	24 Hrs. Min.	8. Date of Birl (Month, Da July 03	th y, Year)	ntgom	Birthplace (Sta	te or Foreign
	D	tor	Usual Residence of Decedent 10a. State 10b. County MD Montgot	nerv		Town or Lo					July 03	1)2	- Wa	10d. Insid	e City Limits
	d within 72 hours after death with the Maryland jiene. I'r than "natural", or Itams 23a or 28a-1 show I're Medical Examfrer must be rodified at	eral Director	10e. Street and Number 2015 East West] 11. Marital Status				10f. Zip	Code	spanic Orio	tin? (Sne	cify Yas or No	Ţ	zen of What JSA	Country?	
-0036	hours after d tural', or Itan al Examiner	ed by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 Tes 2 If Yes, Give Year or Date	es? Sk ^{No}		f Yes, speci 1 ☐ Yes 2 dent's Usual	[₹No	Specify:	Puerto I	cify Yes or No Rican, etc.)		Black, W	hite, etc. Black	···
121215-0036	within iene. r than "	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4		(Give life. l	kind of word DO NOT use rical	k done d e retired)	uring most			Cit	ibank	of NY.	
aryland	should b nd Mente markad	To Be	17. Father's Name (First, Middle, Last, Van Bunn O' Ke 11 19a. Informant's Name/Relationship (7		19b. Mailir	ng Address	(Street a	Eth	el C	(First, Middle, lifton Route Numbe		,	e, Zip Code)20	0772
altimore, Maryland	ages 1 and 2 nt of Health a t: If itam 27 ls / or othar tree		Barbara Butler/Co	Removal from Sta	ate C6	lace of Dispo emetery, cren	sition (Nam natory or oth	e of her place)	D	d Ct. I	20c. Lo	cation - City	or Town, State	
Baltir	parmit. Pages 1 Department of H Important: If its any injury or ot once.		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer		Нат		. Name and	Addres	s of Facility		-05 shall's Washing	s Fur		Home	
	Pnysician /Medical		23a. Part1. Ener the disease, or com shock!— Immediate Cause (Final disease or condition resulting in death)	aSe	sed the death h line. PISIS as a consequ		er the mode	of dying	, such as c	cardiac o	r respiratory ar	rest,		Approxii Interval Onset a	mate Between nd Death
	Examiner pu	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Pi	neumon i as a consequ	ia									
68760,	death certificate be exacuted e attending physician and of for use as the buriat-transit	edical Exa	resulting in death) Last		as a consequ	ience of);									
.O. Box	s that the death certific ned by the attending p s detached for use as I	Physiclan/Medlcal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ☐ Fetal t at time of de	death 3	Ectopic pre Other (spe					2	3d. Date of o	delivery Day	Year
s, P	equires sen sign ould be	by	Part II. Other significant conditions of Urinary Trac	_		Ilting in the ur	nderlying ca	use give	n in Part I.			bacco us		to the cause	
Vital Record	The la ate has page 2	e Completed	25. Was case referred to medical						26 Place	of Death	24a. Was a autop perfor 1 Yes	sy med? 2X No	prior t death	autopsy findin o completion o? es 2 \(\sum No	
of	S S S	atlon: To B	examiner? 1 Yes 2 XNo 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation			ER/Outpatien 28b. Time of Injury		c. Injury Work	r: 4 □ Nur at	sing Horr 2	ne 5 Resid	lence 6		pecify)	
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not b	building,	etc. (Specify,						8f. Location (S City or Tow	m, State)			umber,
	To the Hospital or within 24 hours after the Funeral Dir. completely filled in I	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Ph 2 ☐ Medical Exam 29b. Signature and title of certifier	ysicien: To the be niner: On the basi and manner	s of examinati	vledge, death ion and/or inv	estigation, i	t the time n my opi License	nion, death	place, a	d at the time, o	date and	place, and d	as stated. ue to the caus nth, Day, Year	
	13		30. Name and address of person who	completed cause	of death (Item	23a) (Type, I		-323	32			1-1	4-05		
	Sta		Suresh K. Gupt 31. Date filed (Month, Day, Year) JAN 2 5 2005	a, M.D. 32. Reg	1500 strar's Signati	Forest	G1en	Roa	d, Si	lver	Sprin	g, M	D. 209	10	
	Registr	aı	UMIT	700	1										

		1 - State Registra MEND#17perIN	State of Marylar £1/26/05.BW.McCo		rtificate of Death			ene 005	03540
		Decedent's Name (First, Middle, L.)					Date of Death	9.140.	3. Time of Death
Physic		Frances	K. Margoli	íc			Month	Day Yea	M
/Medi Exami		4a. Facility Name (If not institution, gr	0	LS	4b. City, Town, or Location of		mary	13 200 4c. County of De	
Exam	101	Sunrise			Silver Spring	7		Monts	gomery
Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year If Under		Date of Birth Month, Day,		
Director		577-52-5060	1 □ M 2 🔀 F	97 Yrs.	Months Days Hours	Min. Ap	ril 19	,1907 Wes	Sirthplace (State or Foreign Country) St Virginia
, n		Usual Residence of Decedent 10a. State 10b. County	100 0	by Taum and					
anyla shov	-	Toa. State Tob. County	100. 01	ty, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 🔀 No
86-1 86-1	Director	Maryland Montgon	nery S	ilver					
with ti	Dir	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (Country?
illed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or Items 23e or 28e-f show ant, the Modical Exc. inter mat be notified at	Funeral	15022 Snowden Dri	ve 12. Was Decedent Ever in U	C 10	20905			U.S.	
iter de	Š	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	.5. 13.	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican	n, Puerto Rica	n, etc.)	Black, Wh	nerican Indian, nite, etc.
irs af	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No Specify:			Specify:	77
2 hours a atural', c	ted	15. Decedent's E	Education	16a. Dece	dent's Usual Occupation		16	6b. Kind of Busines	White s/Industry
n "n	pie	(Specify only highest gi	rade completed) College (1-4or 5+)	(Give	kind of work done during most DO NOT use retired)	t of working			,
d with	Completed	Clementary/Secondary (0-12)	5	Teach	er		E	ducation	
e file of the vant,	3e C	17. Father's Name (First, Middle, Las Kaplon	t)		18. Mothe	er's Name (Fir	st, Middle, Ma	aiden Sumame)	
uld be fill Aental Hy rked oth	To B	Abraham Margolia	,		Bessi	ie G. R	af1o		
sho and N s me		19a. înformant's Name/Relationship	(Type, Print)	19b. Mailii	ng Address (Street and Number	er or Rural Ro	ute Number,	City or Town, State	, Zip Code)
and alth		Jerry Samet / Le	gal Guardian	15022	Snowden Drive	, Silv	er Spr	ing, Mary	land 20905
of He	-	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Place of Dispo	sition (Name of natory or other place)	Date	20	Oc. Location - City of	or Town, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any july or other traumatic evant, the Modeal Exacultural be notified at once.	,	'4 Donation 5 Other (Spec		ean Me	morial Garde	1/14/2	005 0	lney, Man	rvland
partr portr y inj		21. Signature of Funeral Service Lice			. Name and Address of Facility			DI FUNERA	AL HOME, INC
89 E 29		Sant. Wil	e	11	800 New Hampsh	ire Av	e. Sil	ver Sprin	ng, MD 20904
		23a. Pur . Enter the disease, or cor shock, or heart failure. List only	nplications that caused the deat	h. Do not ent	er the mode of dying, such as	cardiac or res	piratory arres	it,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a Cardiac Ven	triou1	or orrhethmic				Onset and Death 8 months
/Medical		resulting in death)	Due to (or as a conseq		ar arrnythmra				o months
Examiner	ı	Sequentially list conditions	b						
ъ ±	ie.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin.	Due to (or as a conseq	uence of):					
acute ind trans	Examiner	Cause (Disease or injury	C						
a c le		that initiated events							
uri e	-	resulting in death) Last	Due to (or as a conseq	uence of):					
ate be e hysiciar the buri	cai	resulting in death) Last	Due to (or as a conseq	uence of):					
artificate be ing physiciare as the buri	cai	resulting in death) Last	d						
ath certificate be to tending physiciar or use as the buri	cai	resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	d	ancy	Ectopic pregnancy			23d. Date of d	•
e death certificate be executed the attending physician and ned for use as the burial-transit	cai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	d. 23c. If yes, outcome of pregna	ancy	Ectopic pregnancy Other (specify)			23d. Date of d	elivery Day Year
hat the death certificate be ed by the attending physiciar	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	ancy Ideath 3 [eath 5 [Other (specify)		22a Digitaha	Month	Day Year
res that the death certificate be signed by the attending physiciar to detached for use as the buri	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown Part II. Other significant conditions	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	ancy I death 3 [leath 5 [Other (specify)	. :		Month cco use contribute	Day Year to the cause of death?
requires that the death certificate be een signed by the attending physiciar nould be detached for use as the buri	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	ancy I death 3 [leath 5 [Other (specify)	.		Month cco use contribute	Day Year
'aw requires that the das been signed by the 2 should be detached	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown Part II. Other significant conditions	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	ancy I death 3 [leath 5 [Other (specify)		1 ☐ Yes 24a. Was an autopsy	Month cco use contribute 2 \(\text{No} \) 3 \(\text{F} \) 24b. Were a prior to	Day Year to the cause of death? Probably 4 Munknown autopsy findings available
'aw requires that the das been signed by the 2 should be detached	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown Part II. Other significant conditions Malnutrition	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	ancy I death 3 [leath 5 [Other (specify)		1 ☐ Yes 24a. Was an	Month cco use contribute 2 \[\text{No} \] 3 \[\text{F} \] 24b. Were a prior to death?	Day Year to the cause of death? Probably 4 Munknown autopsy findings available
law requires that the das been signed by the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown Part II. Other significant conditions Malnutrition	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown contributing to death but not res	ancy I death 3 [leath 5 [Other (specify)	of Death (Che	1 Yes 24a. Was an autopsy performe Yes 2 5	Month cco use contribute 2 \(\text{No} \) 3 \(\text{F} \) 24b. Were a prior to death? 3 \(\text{No} \) 1 \(\text{Ye} \)	Day Year to the cause of death? Probably 4 ⊠Unknown autopsy findings available completion of cause of s 2□ No
law requires that the das been signed by the	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown Part II. Other significant conditions Malnutrition Severe Anemia 25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No	23c. If yes, outcome of pregna 1	ancy Il death 3 [leath 5 [leath 5 [leath 5 [leath]]]	Other (specify) 26. Place t 3 DOA	of Death (Charsing Home	1 Yes 24a. Was an autopsy performe Yes 2 5 eck only one) 5 Residence	Month cco use contribute 2 No 3 F 24b. Were a prior to death? 1 No 1 Ye ce 6 MOther (Sp.	Day Year to the cause of death? Probably 4 ⊠Unknown autopsy findings available completion of cause of s 2□ No
ng Physicien: The law requires that the differ this certificate has been signed by the uneral director, page 2 should be detached	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown Part II. Other significant conditions Malnutrition Severe Anemia 25. Was case referred to medical examiner?	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown contributing to death but not res	ancy Il death 3 [eath 5 [ulting in the u	26. Place t 3 DOA Other: 4 Nur 28c. Injury at Work?	of Death (Chersing Home 28d. I	1 Yes 24a. Was an autopsy performe Yes 2 5 eck only one) 5 Residence	Month cco use contribute 2 \(\text{No} \) 3 \(\text{F} \) 24b. Were a prior to death? 3 \(\text{No} \) 1 \(\text{Ye} \)	Day Year to the cause of death? Probably 4 ⊠Unknown autopsy findings available completion of cause of s 2□ No
ng Physicien: The law requires that the differ this certificate has been signed by the uneral director, page 2 should be detached	To Be Completed by Physician/Medical	resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown Part II. Other significant conditions Malnutrition Severe Anemia 25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 □ Pending investigation	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown contributing to death but not res Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	eath 3 eath 5 ulting in the unserted seath 5 eath 5 eath 5 eath 10 eat	26. Place t 3 DOA Other: 4 Nur 28c. Injury at Work? M 1 Yes 2 N	of Death (Chersing Home 28d. I	1 Yes 24a. Was an autopsy performe Yes 2 5 eck only one) 5 Residence Describe how	Month cco use contribute 2 No 3 F 24b. Were a prior to death? No 1 Ye ce 6 SO Other (Sp. injury occurred	Day Year to the cause of death? Probably 4 ©Unknown autopsy findings available completion of cause of s 2 \(\) No SSISTED
ng Physicien: The law requires that the differ this certificate has been signed by the uneral director, page 2 should be detached	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregna 1	eath 3 [leath 5 [leath 5 [leath 5 [leath 5 [leath 5 [leath 5 [leath]]]]]	26. Place t 3 DOA Other: 4 Nur 28c. Injury at Work? M 1 Yes 2 N	of Death (Chersing Home 28d. I	1 Yes 24a. Was an autopsy performe Yes 2 5 eck only one) 5 Residence Describe how	Month cco use contribute 2 No 3 F 24b. Were a prior to death? X No 1 Ye ce 6 XOther (Sp injury occurred	Day Year to the cause of death? Probably 4 ⊠Unknown autopsy findings available completion of cause of s 2□ No
ng Physicien: The law requires that the differ this certificate has been signed by the ineral director, page 2 should be detached	Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregna 1	eath 3 [leath 5 [leath 5 [leath 5 [leath 5 [leath 5 [leath]]]]	26. Place t 3 DOA Other: 4 Nul 28c. Injury at Work? M 1 Yes 2 N	of Death (Charsing Home 28d. I	1 Yes 24a. Was an autopsy performe Yes 2 2 9ck only one) 5 Residence Describe how ocation (Street)	Month cco use contribute 2 No 3 F 24b. Were a prior to death? 3 No 1 Ye ce 6 20 Other (Sp injury occurred et and Number or F State)	Day Year to the cause of death? Probably 4 Munknown autopsy findings available completion of cause of s 2 No SSISTED Bural Route Number,
ng Physicien: The law requires that the differ this certificate has been signed by the ineral director, page 2 should be detached	Certification; To Be Completed by Physician/Medical	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregna 1	eath 3 Eeldh 3 Eeldh 5 ER/Outpatien 28b. Time of Injury	26. Place t 3 DOA Other: 4 Nut 28c. Injury at Work? M 1 Yes 2 N eet, factory, office	of Death (Chersing Home 28d. I	1 Yes 24a. Was an autopsy performe Yes 25 ack only one) 5 Residence Describe how ocation (Street) ity or Town, Supplied to the cause to the cause	Month cco use contribute 2 No 3 F 24b. Were a prior to death? 1 Ye ce 6 XOther (Sp injury occurred et and Number or F State)	Day Year to the cause of death? Probably 4 Munknown autopsy findings available completion of cause of second sec
ng Physicien: The law requires that the differ this certificate has been signed by the ineral director, page 2 should be detached	Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnation of the contributing to death but not result and the contribution of the contribut	eath 3 Eeldh 3 Eeldh 5 ER/Outpatien 28b. Time of Injury	26. Place t 3 DOA Other: Work? M 1 Yes 2 N eet, factory, office	of Death (Chersing Home 28d. I	1 Yes 24a. Was an autopsy performe Yes 25 ack only one) 5 Residence Describe how ocation (Street) cue to the causthe time, date	Month cco use contribute 2 No 3 F 24b. Were a prior to death? No 1 Ye ce 6 MOther (Sp injury occurred et and Number or F State) se(s) and manner as and place, and du	Day Year to the cause of death? Probably 4 Tunknown autopsy findings available completion of cause of s 2 No SSIST ed Bural Route Number, Stated. e to the cause(s)
Physicien: The law requires that the d this certificate has been signed by the ral director, page 2 should be detached	To Be Completed by Physician/Medical	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregna 1	eath 3 Eeldh 3 Eeldh 5 ER/Outpatien 28b. Time of Injury	26. Place 26. Place 27. Other: 4 Nur 28. Injury at Work? M 1 Yes 2 Nur 29. License number	of Death (Chersing Home 28d. I	1 Yes 24a. Was an autopsy performe Yes 25 25 Residence Describe how acation (Street) acation (Street) action (Street) a	Month cco use contribute 2 No 3 F 24b. Were a prior to death? 1 No 1 Ye ce 6 MOther (Sp injury occurred et and Number or F State) se(s) and manner as and place, and du Date signed (Montal)	Day Year to the cause of death? Probably 4 **DUnknown autopsy findings available of completion of cause of some series of s
ng Physicien: The law requires that the differ this certificate has been signed by the ineral director, page 2 should be detached	Certification; To Be Completed by Physician/Medical	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregna 1	eath 3 [leath 5]]]]]] ER/Outpatien 28b. Time of Injury 20me, farm, strivition and/or invitation and/	26. Place t 3 DOA Other: 4 Nui 28c. Injury at Work? M 1 Yes 2 Neet, factory, office	of Death (Chersing Home 28d. I	1 Yes 24a. Was an autopsy performe Yes 25 25 Residence Describe how acation (Street) acation (Street) action (Street) a	Month cco use contribute 2 No 3 F 24b. Were a prior to death? No 1 Ye ce 6 MOther (Sp injury occurred et and Number or F State) se(s) and manner as and place, and du	Day Year to the cause of death? Probably 4 **DUnknown autopsy findings available of completion of cause of some series of s
ng Physicien: The law requires that the differ this certificate has been signed by the ineral director, page 2 should be detached	Medical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregna 1	ER/Outpatien 28b. Time of Injury ome, farm, str. wledge, death tion and/or inv	26. Place t 3 DOA Other: 4 Nur 28c. Injury at Work? M 1 Yes 2 Neet, factory, office cestigation, in my opinion, deat 29c. License number D 10298 Print)	of Death (Chersing Home 28d. I	1 Yes 24a. Was an autopsy performe Yes 25 eck only one) 5 Residence Describe how ocation (Street) or Town, 3 use to the cause the time, date 29d Jan	Month cco use contribute 2 No 3 F ad? 24b. Were a prior to death? 1 Ve ce 6 XOther (Sp injury occurred et and Number or F State) se(s) and manner as and place, and du Date signed (Montrulary 13,	Day Year to the cause of death? Probably 4 **DUnknown autopsy findings available of completion of cause of some series of s
To the Hospital or Attending Physicien: The law requires that the dwithin 24 hours after decrease. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Medical Certification; To Be Completed by Physician/Medical	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregna 1	ER/Outpatien 28b. Time of Injury wledge, death tion and/or inv	26. Place t 3 DOA Other: 4 Nui 28c. Injury at Work? M 1 Yes 2 Neet, factory, office	of Death (Chersing Home 28d. I	1 Yes 24a. Was an autopsy performe Yes 25 eck only one) 5 Residence Describe how ocation (Street) or Town, 3 use to the cause the time, date 29d Jan	Month cco use contribute 2 No 3 F ad? 24b. Were a prior to death? 1 Ve ce 6 XOther (Sp injury occurred et and Number or F State) se(s) and manner as and place, and du Date signed (Montrulary 13,	Day Year to the cause of death? Probably 4 **DUnknown autopsy findings available of completion of cause of some series of s

			1 - For State Registrar	State of Man		artment of I rtificate of		Re	g. No.2005	
	Physici	an	Decedent's Name (First, Middle, Last VERONICA THERE					2. Date of Death Month January	Day Year	3. Time of Death 8:00 A M
	/Medi		4a. Facility Name (If not institution, give		-	4h City Town	or Location of Death		4c. County of De	
	Examir	ier	Shady Grove Adven		a1	Rockvil		•	Montgom	
	Funeral		Social Security Number 6. Se	x 7. Age (I	n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		
	Director		195-24-5296 15 Usual Residence of Decedent]M 2[X F	74 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Oct 25	,1930 PA	irthplace (State or Foreign Country)
	Maryland f show	tor	10a. State 10b. County Md. Montgome		Oc. City, Town or Lo Gaithers					10d. Inside City Limits 1 X Yes 2 □ No
	or 28a	Funeral Director	10e. Street and Number			10f. Zip Code			g. Citizen of What C	•
	s 23e	rai	731 Gatestone Str		.:		878		Jnited Sta	
936	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Itams 23a or 28a-f show ther than Madical Examinar must be notified at	b	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of F f Yes, specify Cub 1 ☐ Yes 2 🔯 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Wh Specify: Wh	ite, etc.
15-0	n 72 ho	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	pation during most of world)	king 1	6b. Kind of Business	s/Industry
212	iene. iene. r than	Jwo	Elementary/Secondary (0-12)	College (1-4or 5+)		bly Line		ļ	Gas Meter	s
Maryland 21215-0036	0 4 5 ×	To Be C	17. Father's Name (First, Middle, Last) Salvatore Esola					a Marie M		
Mary	es 1 and 2 should k of Health and Ment litem 27 is marked r other traumatic e		19a. Informant's Name/Relationship (7) Anna Smith (Daug			ng Address (Street Gatestone			City or Town, State,	
re,	of Hea		20a. Method of Disposition	12	20b. Place of Dispo			Date 2	0c. Location - City o	
<u>m</u>	Page nent c		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Tellioval Itolii State	St. Cath	_	Jan.	29, 05 E	uBois, PA	
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Licens	Days		. Name and Addre	. D	eVol Fune Dr. Gaith		Md. 20877
1	Proysician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause of each line.	ive Lung		ng, such as cardiac	or respiratory arres	St,	Approximate Interval Between Onset and Death 5 Years
	/Medical Examiner		resulting in death)	Due to (or as a co						20 Years
	bed sit	Examiner	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence of):					
68760,	death certificate be executed e attending physician and ad for use as the buriat-transit	cai	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):					
P.O. Box 6	that the death certific ed by the attending p detached for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of de Month	livery Day Year
Records, P	Se C 90	b	Part II. Dther significant conditions con Parkinson's Disea		ot resulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba		o the cause of death?
900	e law require has been si je 2 should f	piete	Osteoporosis					24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
_	Th pag	Completed	Hypertension					performe 1 Yes 2	ed? death? ∑No 1 ☐ Yes	_
Viital	Physician: r this certifica ral director, I	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	lospital:	2 C EB/O	Oth		h (Check only one)	0 501 (0	
ō	Ilng Afte fune	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of Injury	28c. Injur	4 L Harsing He	28d. Describe how	ce 6 Other (Spe injury occurred	city)
Divis	i ji ji ji	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
	To the Hospital within 24 hours a To the Funeral to completely filled	Medicai	29a. Certifier 1	ner On the basis of exa and manner stated.	y knowledge, death imination and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and manner as e and place, and due	s stated. to the cause(s)
	Neth John Common	Σ	29b. Signature and title of certifier	Roesho	s Mi	29c. Licenso D2654		1	January 2	* '
	(U		30. Name and address of person who con Dr. Carl I. Schoe				k Rd. Ga	ithersbur	g, Md.208	377
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 4 200	32 Registrar's	14 4	well				

05-00457 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Stephen Malcom State of Maryland / Department of Health and Mental Hygiene, RJD 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 19, January 2005 1713P. Stefan Anthony Malcolm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hyattsville Prince Georges 6638 23rd Ave If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1⊠M 2□F Director 579-15-0750 Feb.12, 1987 Washington, DC Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23a or 28a-f show the Modical Expressives the notified at 1 ☐ Yes 2 ☑ No Directo Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6638 23rd Avenue 14. Race - American Indian, 20782 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 Specify 3 Widowed 4 Divorced **Black** Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Education Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 Is marked any injury or other treumatic ev Horace Carmichael Malcolm Andrea Lee Ellonia Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9505 Worrell Avenue Lanham, Maryland <u>Andrea Johnson</u> Mother 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven 20c. Location - City or Town, State 20a, Method of Disposition Date in in 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Jan. 29, 2005 Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring, MD 20001 Ken Stiles 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician disease or condition resulting in death) marine /Medical Due to (of as) conse **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an autopsy 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Mother (Specify) (SCENE) ို this funeral 28a. Date of Injury (Month, Day Var) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred After (Month, Day - ar, 5 Pending 1 Natural subject hanged 1 7:00 M 2 Accident investigation efter death 3 Suicide 4 ☐ Homicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 0nome within 24 hours e 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and degree the cause(s) and maintenance.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one)

State Registrar

DHMH 17 Rev 1/2001

JAN 24 2005

29b. Signature and title of certifier

STRILLA

31. Date filed (Month, Day, Year)

ne and address of person who completed cause of de

(Item 23a) (Type, Print)

TOLLAK

32 Registrar's Signature

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 20, 2005

111 Penn St., Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JANUARY 20, 2005 **Physician** 1:20P M **MEDJUCK** MAYME /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MONTGOMERY HEBREW HOME OF GREATER WASHINGTON ROCKVILLE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth JAN. 13, 1914 5. Social Security Number 6 Sex **Funeral** Days NEW YORK 1 ☐ M 2 ☐ F 91 127-40-7249 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County or 28a-f show item 27 Is marked other than "naturel", or Items 23a or 28a-f shov other treumatic event, if a Medical Example in ust be notified at 1 Yes 2 No Director MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 UNITED STATES OF AMERICA 6121 MONTROSE ROAD Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married WHITE 1 Yes X No Specify: Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tiem 27 is marked othe any injury or other treumatic event once. Be HARRY HODES ROSE STILLMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7626 CODDLE HARBOR LANE, POTOMAC, MD 20854 HEDDA SILVERMAN - DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SYRACUSE, NEW YORK OAKWOOD CEMETERY 01/23/2005 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee PANGARSEKVILLEBERGEMERSEKOTILLEAPED, 20852 Part __inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Myocardia Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-tran the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 Tes 2 □NO 3 □ Probably 4 □Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed? 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 ☐ Yes 2 ☐ No Mirsing Home 5 Residence 6 Other (Specify) Certification: To 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred 27. Manner of Death Hospital or Attending 5 Pending investigation 1 Natural 2 Accident 1 🗌 Yes 2 - No after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. within 2 To the the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 and address 6121 Montrose Rd Rockville Mis 31. Date filed (Month, Day, Year) State JAN 24 2005 Registrar

DHMH 17 Rev 1/200

Baltimore, Maryland 21215-0036

				For State Registrar			and / Depa	artment of H	lealth and M	lental Hy	giene Reg. No 200	
				1. Decedent's Name (First, Middle, La	ast)					2. Date of De		3. Time of Death
_		Physic		Donald McAdoo							y 23, 2005	4:58 A M
		/Medi Examir		4a. Facility Name (If not institution, given	ve street and nu	mber)		4b. City. Town. or	Location of Death	- Junuar	4c. County of De	
	1			Gilchrist Hospice				Towson			Baltimor	
		Funeral		Social Security Number 6. 8	Sex 12 M 2 □ F	7. Age (In yi	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt		
	П	Director		000-12-4770	14∑M 2□F		86 Yrs.	Months Days	Hours Min.	Sept.	29, 1918 P	Birthplace (State or Foreign Country) ennsylvania
		p		Usual Residence of Decedent		140						<u> </u>
		aryla shov	-	10a. State 10b. County		10c.	City, Town or Lo	ecation				10d. Inside City Limits
		ith the Marylar or 28a-f show	cto	Maryland Howard		La	urel					1 ☐ Yes 2 No
		or 2	Directo	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?
		r 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show calcal Examiner must be notified at	ra	8534 Pineway Driv				20723			USA	
		er de Item	Funeral	11. Marital Status	12. Was Dec	rces?	U.S. 13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto f	cify Yes or No- Rican, etc.)	14. Race - An Black, Wi	nerican Indian, nite. etc.
5	36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 DXYes If Yes, Giv	2∐ No ∕e ates: WWI	т	1 ☐ Yes 2 ☐XNo	Specify:		Specify	
4	5-0036	within 72 hours after ene. then "natural", or Ite	ed	15. Decedent's E		ales. WWI		donte Havel Occurs			W.	hite
00	-	in 72 n "na	Completed	(Specify only highest gr.	ade completed)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	ition Juring most of workir)	ng	16b. Kind of Busines	ss/Industry
75	212	with jene.	mo	Elementary/Secondary (0-12)	College (1	-4or 5+)	Capta				Army	
Ö	b	i filec I Hyg othe	Q)	17. Father's Name (First, Middle, Last)		- Jone -		18. Mother's Name	(First, Middle,		
	ar	ald be fenta rked ic sv	To B	William McAdoo					Edith Kie		,	
	Maryland	shound N	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ig Address (Street a	nd Number or Rural	Route Numbe	r, City or Town, State	Zin Code)
6	Ξ	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. item 27 Is marked other then "natural", or Items 23a or 28a-f shov other treumatic svent, I'm Madical Examiner must be notified at		Dennis C. McAdoo/	son						Maryland	
10	e,	s 1 a of Hei item othe		20a. Method of Disposition		20b	Place of Dispo		D	ate	20c. Location - City of	
W	Ë	Page bent c nt: If		1 ☐ Burial 2 XCremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Special				el Cremate	Julia		Odonton	Manual and
N	Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then any injury or other treumatic event, IT u.M. 2010e.		21. Signature of Funeral Service Lice			22	Name and Address	s of Facility		Odenton, 1	
-	Ö	Departing Department of the second of the se		Beverly L. K	teste	. Me	01251 B	oing Home	Crematio	n Servi	ce P.O. I	Box 784 Lle, MD 21029
				23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that c	aused the de	ath. Do not ente	er the mode of dying	, such as cardiac or	respiratory arr	CIALKSVI. est,	Approximate
	. I	Physician		Immediate Cause (Final	one cause on e	acri mue.	men	4:0				Interval Between Onset and Death
		/Medical		disease or condition resulting in death)	a Due to (or as a conse		ICA				year
3		Examiner					4001100 017.					
7	L,		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):					
Reire		be executed sician and burial-transit	Examiner	that initiated events	C.							
0	o,	an an	Ë	resulting in death) Łast	Due to (or as a conse	equence of):					
	8760	# × @	cal	(d							
0	9	certifica Iding ph	Physician/Med	IF FEMALE:								
7	Вох	th cer tendin or use	an/I	23b. Was decedent pregnant	23c. If yes, out	ome of pregath 2 ☐ Fe		Ectopic pregnancy			23d. Date of de	Blivery
1	-	ie deati the atte	slci	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of		Other (specify)			Month	Day Year
<	P.0	that the d ed by the detached	Phy	9 Unknown								
0	S,	The law requires that the death the has been signed by the atter vage 2 should be detached for u	by	Part II. Other significant conditions of	ontributing to de	ath but not re	1	derlying cause giver	n in Part I.		\ a	to the cause of death?
	ord	w requires been sign should be	ted	Corigestion	e vien	VI	Ach			1 🗆 Ye	es 202No 3 P	robably 4 Unknown
_	Rec	law lasb	Completed by	J						24a. Was a autops		utopsy findings available completion of cause of
0	E =		Con							perform	ned? death?	s 2 No
0	Vital	cien: ertitic	Be	25. Was case referred to medical examiner?					26. Place of Death (/ -	
()	of \	Physicien: this certificatal director,	<u>o</u>	1 ☐ Yes 2 No			ER/Outpatient	3 DOA Other	4 Nursing Home	e 5 Reside	ence 6 Other (Spe	OCITY) HOSPIC
1		ing Phys	Certification:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date o (Mont)	f Injury 1, <i>Day Year)</i>	28b. Time of Injury	28c. Injury a Work?	at 28	d. Describe ho	w injury occurred	7
7	sion	tend leath tor: / the t	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be					es 2 No			
5	<u>></u>	or At	ırt	4 Homicide determined	28e. Place	of Injury - At I g, etc. <i>(Sp</i> ec	nome, farm, stre <i>ify)</i>	et, factory, office	28	If. Location (Sti City or Town	reet and Number or R n, State)	ural Route Number,
		pitet ours a erel I	2	One Continue Amountain Di								
		Hos 24 ho Fun stely 1	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	inter: On the ba	sis of examin	owledge, death ation and/or inv	occurred at the time estigation, in my opir	, date and place, an nion, death occurred	id due to the ca	tuse(s) and manner at ate and place, and du	s stated. e to the cause(s)
		To the Hospitet or Attending Phys within 24 hours atter death. To the Funerel Director: After this completely filled in by the tuneral dir	Mec	29b. Signature and title of certifier	and mann	stated.		29c. License r				
		F ≱ ∓ 8		VI Hart	mal 1.	1,0.	und				Date signed (Moni	
				30 Name and 11 1/2	4 10	7	100-17	100	7003		my nory	27,2005
(~)	1/	0		30. Name and address of person who	completed cause	of death (Ite	n A	(Chan	le (+.	Balt	- Ald	21208
(3	10	Stat	e	31. Date filed (Month, Day, Year)	32. Re	strar's Sign			>-/	1000	0. 1003	
		Registra		<u> </u>	2005	leeve	B 6	serle				

		Please	State of Maryla				•	_	
		For State	State of Maryla		rtificate of			g. No. 200	5 0351
-		Registrar Decedent's Name (First, Middle, Last)				2. Date of Death	1	3. Time of Death
Physici		Cathe	erine M. McVe	iah			January	Day Year 2005	7:35 A ^M
/Medic Examin		4a. Fecility Name (If not institution, give			4b. City, Town, o	r Location of Death	h	4c. County of Dee	th
		Howard County Gene	eral Hospital		Columb			Howard	
Funeral		5. Social Security Number 6. Se	M 2DTE	s. last birthday, Yrs.	If Under 1 Year Months Days	Hours Min.	(Month, Dey,	Yeer) 9. Bit	thplece (Stete or Foreign ountry)
Director		078 12 9096 Usual Residence of Decedent	87	115.			Dec 18,	1917 Vi	rginia
land w		10a. State 10b. County	10c. 0	City, Town or L	ocation				10d. Inside City Limits
Mary In the	to	MD Howard		Columbi	ia				1 ☐ Yes 2 🔯 No
h the	lrec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
death with the Maryland ms 23a or 28a-f ehow rms 1 be notified at	Funeral Director	5400 Vantage Point	: Road		210			United 9	
r dea	nue	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
hours after tural; or Ite	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	¹Ž⊡Yes 2 ☐ No If Yes, Give Year or Dates: WWI	т	1 ☐ Yes 2X No	Specify:		Specify: V	/hite
		15. Decedent's Edi	ucation	16a, Dece	edent's Usual Occup	pation		16b. Kind of Business	
	piet	(Specify only highest grad	de completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wor d)	rking		
¥ 5 ± €	Completed	Elementary Cooperatry (o 12)	4	Die	etician			Hospital	
I be filed ntal Hygi od other	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, A		
should by	2	Seward H. Marsh					. Woodwar		
inal yially id 2 should be filt th and Mental H; 27 Is marked oth traumatic event		19a. Informant's Name/Relationship (7	_					City or Town, State,	Zip Code)
	١.,	Mary Louise Stade: 20a. Method of Disposition			Links Lei	th Willia		VA 23188 20c. Location - City o	r Town, State
Pages nent of th		1 ☐ Burial 2X Cremation 3 ☐	Removal from State	cemetery, cre	ematory or other pla cematory			Catonsvill	
mit. Pages 1 a partment of Her portent: If Item y injury or other £29.		*4 □Donation 5 □Other (Specify 21. Signature of Funeral Service Licen:				-			nily FH Inc.
permit. Pages Department of I Importent: If Its eny injury or o		Stem Collin	With						, MD 21043
		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only	olications that/caused the de						Approximate Interval Between
Physician		Immediate Cause (Final	, Sepsis						Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a cons	equence of):					
Examiner		Sequentially list conditions	b. Pneumonia						7 days
D =	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to (or as a cons	equence of):					
ou, be executed ician and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	equence of):					I .
be executed sician and burial-transit	三田 田田								
DOX OO /			d						
death certificate attending physed for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pres		Or:			23d. Date of de	elivery
the death cer y the attending ached for use	icia	in the past 12 months? 1 □ Yes 2 No	1 Live birth 2 Fo		□Ectopic pregnanc □ Other <i>(specify)</i> _	у		Month	Day Year
	hys	9 Unknown	9□ Unknown						
The law requires that the law sequires that the law been signed by the page 2 should be detached.	by	Part II. Other significant conditions of	ontributing to death but not r	esulting in the	underlying cause gr	ven in Part I.			to the cause of death?
v require	ted								robably 4 Unknown
alaw las b	Completed						24a. Was a autops perform	y prior to	utopsy findings available completion of cause of
The cate l	Co						1 ☐ Yes 2		s 2 No
Or Vital ned Physician: The lav rthis certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		Ot	hor	ath (Check only on		
Phys rthis	- To	1 Yes 2 No 27. Manner of Death	28a, Date of Injury	☐ ER/Outpatie	#IL 3 DOA	4 Nursing r		ince 6 Other (Sp ow injury occurred	ecity)
ding Ith.	to	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yeer,) Injury		rk?]Yes 2∐No			
UNISION OF WIRD INCOLORS, for Attanding Physician: The law requires th affer death. Director: After this certificate has been signe i in by the funeral director, page 2 should be d	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe		treet, factory, office		28f. Location (St. City or Town	reet and Number or F	Rural Route Number,
s after safter bird	Certification:	4 [] Homicide	building, etc. (Spe				Oily or your	., 01410)	
Hospital			ysicien: To the best of my lainer: On the basis of exam						
- (V - 0	Medical	one)	and manner stated.		29c. Licen			9d. Date signed (Mor	
To the within To the comple	2	29b. Signature and title of certifier	1110	1111					
		1 yespell	VAU	10m 222 7	D030	/63		January 20	0, 2005
)az		30. Name and address of person who Michael G. Macon	completed cause of death (I 4801 Dorsev F	Hall Dr	ive #222	Ellicott	City, MD	21042	
	ate	31. Date filed (Month, Day, Year)	32. Pegistrar's Si		2-341				
Regist		JAN 2 5 2	2005 Alalyan	12	A W.				

			For	State of Marylan					_	10-10-10-10-10-10-10-10-10-10-10-10-10-1
			1 - State Registrar		Cei	rtificate of l	Death	Re	eg. No. ZUU	5 03546
	Physici	an	1. Desedent's Name (First, Middle,	Last)		Μ.		2. Date of Deat Month	Day Y	3. Time of Death
	/Medic	al	Drent			May	Location of Death	bnuar	4c. County of	
	Examin	er	4a. Fecility Name (If not institution,	1 11	\ \	4b. City, Town, of	Location of Death		None	
	Funeral Director		5. Social Security Number 215 94 4974	6. Sex 7. Age (In yrs. 14 M 2 F 26	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV 6,	Year) 9.	Birthplece (State or Foreign Country) Maryland
	2		Usuel Residence of Decedent 10a. State 10b. County	100 6	ty, Town or Lo					10d. Inside City Limits
	ahov	5								1 ☐ Yes 2 ☒ No
	28a-f	Director	MD Balt:	TIDLE C	atonsv	10f. Zip Code		1	0g. Citizen of Wha	at Country?
	3e or		126 Westowne Pla	ace		21229)		United	States
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of H	ispanic Origin? (Spe In, Mexican, Puerto I	cify Yes or No-		American Indian, White, etc.
36	hin 72 hours after death with the Maryland e. In "natural", or Itama 23e or 28e-f ahow Madical Examinational buindlist at	by Fu	1⊠ Never Married 2 Marrie 3 Widowed 4 Divorced	nd 1 □ Yes 2 No If Yes, Give		1 ☐ Yes 2X No	Specify:	, , ,	Specify:	
Ö	hours tural'	ed b	15. Decedent'	Year or Dates:	16a Dece	dent's Usual Occup	ation		16b. Kind of Busin	White
15	⊆ 9	Completed	(Specify only highest Elementary/Secondary (0-12)		(Give life.	kind of work done of DO NOT use retired	during most of working)	ng		,
212	i wild and a series	E O	Clementary/Secondary (0-12)	4	Elec	trical Er	ngineer		Engineer	ing
pu	be filed tal Hygid d other	Be (17. Father's Name (First, Middle, L				18. Mother's Name		Maiden Sumame)	
yla	D & 2 0	၉	Douglas C. Mayer				Irene C.			. = 0.41
Maryland 21215-0036	12 17 14 15		19a. Informant's Name/Relationsh				and Number or Rura			
	s 1 and 2 f Health item 27 other tre		Douglas C. Mayer 20a. Method of Disposition		126 Place of Dispo	WESTOWNE sition (Name of matory or other place	Place Cat		20c. Location - Cit	
OE.	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp	3 Mueurovar ironi 2rare		e Park Cer		-2005	Baltimor	s MD
Baltimore,	arth orts inju	1	21. Signature of Funeral Service L	1.10	1044^{-22}	2. Name and Addres	ss of FacilityHarr	v H. Wi	tzke's F	amily FH Inc.
ä	Dep Per		Dum Coll	s-Wille	4	112 Old C	columbia P	ike Ell	icott Ci	ty, MD 21043
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that caused the deat only one cause on each line.	h. Do not ent	er the mode of dyin	g, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		tmmediate Cause (Finat disease or condition	_a Intracvar	ial	hemorr	nagel	nontro	umatio	c Iday
	/Medical Examiner		resulting in death)	Due to (or as a conseq		1 m/1:	0	emia		11
		-	Sequentially list conditions,	b. Unionic Due to (or as a conseq	luene of)	nocytic	LICUN	CWIA		months
	ited insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	4		***				
oʻ	eath certificate be executed attending physician and for use as the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):					
1760,	ate be nysicia he bu	cal	1	d						
89)	The law requires that the death certifical ate has been signed by the attending phroage 2 should be delached for use as the	Physician/Med	IF FEMALE:							
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna	I death 3	Ectopic pregnancy			23d. Date o Month	· ·
0	that the de led by the a detached t	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of d 9 Unknown	19a(ii 5)	Other (specify)				
<u>a</u>	res that tigned by		Part II. Other significant condition	ns contributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribu	ute to the cause of death?
of Vital Records,	quires in sign	ed by						1 □ Ye	s 2□No 3[Probably 4 Unknown
000	aw require is been si 2 should b	Completed						24a. Was a		re autopsy findings available or to completion of cause of
R		E O		_				perform	ned? dea	th? Yes 2 No
/ita	ician: Th certificate ector, pag	Be (25. Was case referred to medical examiner?				26. Place of Death	(Check only on	θ)	
→	hys his II dir	ို	1 ☐ Yes 2 No		ER/Outpatier		4 🗀 Nuising Hor		nce 6 Other (
n (lon	27. Magner of Death 1 Natural 5 ☐ Pending 2 Accident investig		28b. Time o Injury	Worl	yat k? Yes 2 □ No	sad. Describe no	w injury occurred	
Division	al or Attending P : after death. I Director: After t d in by the funera	fica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of Injury - At he	ome, farm, sti			28f. Location (St	reet and Number of	or Rural Route Number,
S	after after Dire	Certification:	4 Homicide	building, etc. (Specif	(y)	•		City or Town	, State)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of my knows examiner: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred at the time vestigation, in my of	ne, date and place, a pinion, death occurre	and due to the ca	ause(s) and manne ate and place, and	er as stated. I due to the cause(s)
	To the To the comp	M	29b. Signalure and title of certifier			29c. License	5 5 3 0.1	5	9d. Date signed (A	Aonth, Day, Year)
(3)	02		13 / 11	who completed cause of death (Item	m 23a) (Type,	Funt) S4	5 5 3 0 1 Balt 1.1	none	MD 21	2.87
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2	32. Redistrar's Signa	ature	barti)				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Ruth Irene Mount January 23, 2005 0639 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Union Hospital of Cecil County Elkton Cecil | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 19, 1911 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 🖾 F 220-20-7018 Director 93 Yrs Pennsylvania Usual Residence of Decedent the Maryland Show 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-1 show any injury or other traumetic event, the Medical Examiner must be multified at once. 10d. Inside City Limits Director Maryland Cecil Perryville 1 Yes 2 □ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 649 Aiken Avenue 21903 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by 3 Nidowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Edgewood Arsenal Elementary/Secondary (0-12) College (1-4or 5+) Eleven Years File Clerk Edgewood, Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Walter Snyder Elsie Blanch Pomraning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn I. Anderson (Daughter) P.O. Box 43, Perryville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mark's Cemetery ^¹ 4 □ Donation 5 □ Other (Specify) 01/29/05 Perryville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 TELL RISON SO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death NEUMONIA Physician /Medical Due to (or as a consequence of): Examiner *JEHYDRATION* 2 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and attending physicien a Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a d be detached f 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 should 1 Yes 2 No 3 Probably 4 Unknown Completed been s certificate has t director, page 2 s 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Yes 2 No Hospital or Attending Physician: funeral director, Be 25. Was case relerred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 [Inpatient 2 1 Yes 2 VNo Other: 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 ☑Natural 5 Pending investigation after death. Director: Af 2 Accident 1 Yes 2 No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALOK RUSTOGI, MD. UNION HOSPITAL., ELKTON, MARYLAND 2192 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 20b per Th 9840 2-4-05 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 4 UU 1. Decedent's Name (First, Middle, Last) 2. Date of Oeath **Physician** 31^{ay} 200⁵ Jan Lloyd Allen Moore 10:30P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frostburg Allegany St. Vincent DePaul Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Yea June 27 Social Security Number ^{Year)} 192<mark>5 Maryland</mark> **Funeral** 1**√** M 2□ F Months Days Hours Yrs. Director 218-16-4477 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner rough be notified at MD Allegany Lonaconing 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17111 Old Georges Creek Rd SW 21539 USA Items 23a Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. ant: if item 27 is marked other than "natural", or Items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No ww11 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0·12) College (1-4or 5+) Pitts. Paint & Glass Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Moore Anna (Timney) Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21539 19a. Informant's Name/Relationship (Type, Print) 17111 Old Georges Creek Rd, Lonaconing, MD Eleanor Grace Moore -Wife other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 2-3-05 Burial 2 ☐ Cremation 3 ☐ Removal from State 0 permit. Page Department of Important: if any injury or once. Laurel Hill Cem. 2Feb 3 05 Moscow Mills, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Sunature of Funeral Service Licensee Hafer Funeral Service PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementia Physician advanced two years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 2**X** No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pendina 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ro the Hospital 29a. Certifier (and manual to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier nonsockes Feb 01, 2005 00055325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frostburg MD 21532 48 Turn Terrace SHIN WONSOCK 31. Date filed (Mooth Day, 32. gistrar's Signature State Registrar

ı	Physici	an	1 - State of Maryland / Dep State of Maryland / Dep Per fh 6840 2-24-09 1. Decedent's Name (First, Middle, Last) Richard Lee Mill		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		31, 2005 4c. County of Deat	
	LXamii	٠,	4365 Ruggles Road	Taneytown		Carroll C	Yountv
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Sept. 26,	9. Birth	hplace (State or Foreign untry)
	Director		217-12-1696 Usual Residence of Decedent		pept. 20,	1924 Mar	yland
	show	_	10a. State 10b. County 10c. City, Town or L Maryland Carroll County Taneyto				10d. Inside City Limits 1 ☐ Yes 2 🕱 No
	the M 28a-f	ecto	10e. Street and Number	10f. Zip Code	100	Citizen of What Co	
	h with	Funeral Director	4365 Ruggles Road	21787		ited Stat	-
	r deat	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1.045	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	rs afte		1 Never Married 2 Married 3 XWidowed 4 Divorced 1 Never Married 2 Married 3 XWidowed 4 Divorced 1 Never Married 2 Married 1 Yes, Give 1946	1 ☐ Yes 2 ☑ No Specify:			hite
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Ecal Examinational be notified at	Completed by	15. Decedent's Education (Specify only highest grade completed) (Give	dent's Usual Occupation	16b	. Kind of Business/	Industry
21	within 7 ene. than "r	mple	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work DO NOT use retired) and operator	tı	rucking c	ompany
	filed w Hygie other t	CO	8 OWITE:		e (First, Middle, Maid		
/lan	uld be dental rked c	To Be	Wilbur Miller	Mary E	llen Renne	er	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Examinational be notified at			ng Address <i>(Street and Number or Rur.</i> Ruggles Road Ta	al Route Number, Cit neytown, N		
Baltimore,	jes 1 ar of Hea If item or other		120 Burial 21 Cremation 3 Hemoval from State	matory or other place)	h 3	. Location - City or	
tim	permit. Pages to Department of Figure 1 in the Important: If its any injury or ot once.		'4 □Donation 5 □Other (Specify) Haugh's	CHurch Cemetery	2005 Lac		Maryland
Ba	Depa Impo			2. Name and Address of Facility Sk 36 East Baltimore	iles Funer Street 7	ral Home Taneytown	, Md. 21787
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final		or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) ALZHEIMER 5 Due to (or as a consequence of):	DEMENTIA			
	Examiner						
	ed sit	lner	Sequentially list conditions, if any, reading to ammediate cause. Enter Underlying Cause (Disease or injury				
۸,	ate be executed thysician and the burial-transit	Examiner	that initiated events c. Due to (or as a consequence of):				
8760	ite be lysicia ne bur		d				
9	leath certificate be attending physicia I for use as the bur	Physiclan/Medical	IF FEMALE: 23c If yes exteems of programmer				
Вох	atter for u	clan/		☐Ectopic pregnancy ☐ Other (specify)		23d. Date of deli Month	very Day Year
P.O.	0 0 9	hysi	9 Unknown 9 Unknown				
	es be		Part II. Other significant conditions contributing to death but not resulting in the CANCER	inderlying cause given in Part I.			the cause of death?
ord	v requir been si should	Completed by	A		1 ☐ Yes	-	obably 4 Honknown
Rec	9 4 9	Jdmo	CORONARY ARTERY DISEASE VALVULAR HEART DISEASE		24a. Was an autopsy performed	? prior to c	topsy findings available completion of cause of
ital	iiclan: Th certificate rector, pag	ø	25. Was case referred to medical		1 ☐ Yes 2X	No 1 ☐ Yes	2 No
) <	Physiclan: this certifical	To B	examiner? 1 Yes 2 X No Hospital: 1 Inpatient 2 ER/Outpatie		me X Residence	6 □Other (Spec	ufy)
Division of Vital Records,	Jing After fune	:lon:	27. Manner of Death 1 XNatural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) Injury	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
/isic	Attending r death. ector: After by the fune	flcat	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Street	and Number or Ru	ral Route Number,
Ö	rs after al Dire	Certification:	4 ☐ Homicide Getermined building, etc. (Specify)		City or Town, St	ate)	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal 2 Medicel Exeminer: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause red at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	To ti Withi. To ti comp	M	29b. Signature and title of certifier M \ D_	29c. License number 29c. License number		Date signed (Month	9005
-	1x1		30. Name and address of person who completed cause of death (Item 23a) (Type, Wasim Fakhar, M.D. 417 E. Balt	Print)	aneytown,	Marriand	21797
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature	THOTE PITEEL 19	ariey cowii,	riar y taniu	21/0/
	Registi	ar	FEB 0 7 2005 Street &	who are			
	MH 17 Rev 1/2						

		1 - For State Registrar	State of Maryla		artment of F			giene Reg. No. 4	2005	0.0.0
Physic /Medi	cal			Myers			2. Date of Dea Month January	30°,	2005	3. Time of Death (
Examii Funeral	ner	4a. Facility Name (If not institution, give st 1538 Baust Church 5. Social Security Number 6. Sex	Road 7. Age (In yi	s. last birthday)	Union	Bridge If Under 24 Hrs Hours Min.	8. Date of Birti	Car	county of Death	ounty place (State or Foreign
death with the Maryland ms 23a or 28a-f show crives be notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Carroll 10e. Street and Number	County	88 Yrs. City, Town or Lo Unior	ocation 1 Bridge 10f. Zip Code		Sept.	9, 19	16 Mar	/land 10d. Inside City Limits 1 □ Yes 2 1 No
72 hours after natural; or ite	Completed by Funeral I	1538 Baust Church 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	16a. Dece (Give life.	If Yes, specify Cub: 1 ☐ Yes 2 No dent's Usual Occup kind of work done DO NOT use retired	dispanic Origin? (S an, Mexican, Puer Specify: pation during most of wo		16b. Kind	ted Stat A. Race - Americ Black, White, Specify: White d of Business/Ir	can Indian, etc. Lte
narylatto ZIZI 2 should be filed within and Mental Hygiene. Is merked othar than " raumatic event, the Ma	To Be Con	7 17. Father's Name (First, Middle, Last) Daniel David Wil.		HOI	emaker		me (First, Middle, hy May St	Maiden S	,	
Dallimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic once.		19a. Informant's Name/Relationship (Typ Elwood A. Myers 20a. Method of Disposition 1 \(\frac{1}{2} \) Burial 2 \(\subseteq \text{Cremation 3 } \) Re 4 \(\subseteq \text{Donation 5 } \) Other (Specify) 21. Signature of Funeral Service License	husband 20b B	1538 Place of Dispo cemetery, crei aust Chi	Baust Consistion (Name of matory or other place urch Ceme	hurch Rocetery Sectory Secto	eb. 3 2005 Siles Fun	on Br 20c. Loca Tyron eral	ridge, Mation - City or The, Md. Home	id. 21791
portou, icate be executed /Medical /was and physician and s the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	ations that caused the descause on each line. CONGESTIC Due to (or as a cons Due to (or as a cons	equence of):	er the mode of dyin	ng, such as cardia	c or respiratory ar			Approximate Interval Between Onset and Death 4 months
ds, F.C. BOX 00/ ires that the death certificate signed by the attending phys tb detached for use as the	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o	etal death 3	Ectopic pregnancy Other (specify)	/		23	d. Date of deliv	ery Day Year
v requ	ompleted by Ph	Part II. Other significant conditions cont	ributing to death but not r	esulting in the u	nderlying cause giv	ren in Part I.	23e. Did to	es 2 /	No 3 □ Prol	he cause of death? pably 4Unknown psy findings available
ate I	e Comp	25. Was case referred to medical				26 Place of De	autop: perfor	sy med? 2 X No	prior to co death? 1 Yes	mpletion of cause of
Phys this	Certification: To B	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	ospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - Al		f 28c. Injur Wor M 1 🗆	er: 4 ☐ Nursing H	Home Resid	ence 6 ow injury	occurred	fy) al Route Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	sal Certif	4 Homicide determined 29a. Certifier 1 Certifying Physic	building, etc. (Spe	ncify)	h occurred at the tir	me, date and place	City or Tow	n, State) ause(s) a	nd manner as s	tated.
To the Hi within 24 To the Fu completel	Medical	(Check only 2 Medicel Exeminone) 29b. Signature and title of certifier	er: On the basis of examinand manner stated.) /	29c. Licens				signed (Month,	
(q	ate	30. Name and address of person who cor William R. Linthi 31. Date filed (Month, Day, Year)		nature 1	Kings Dr	ive	Taneyto	wn,	Marylan	d 21787
Regist		FFR 0 7 2005		K h	and a					

			1 - For State Registrar	State of	Marylan		artment of H		d Mental Hyg	giene neg. No. 0 (05	03551
	Dhysisi	o.m.	1. Decedent's Name (First, Middle, L						2. Date of Dea Month	ith	Vear	3. Time of Death
	Physici /Medio		Felicia Oman						Januar	y 22 2	005	1:55 A M
	Examin	ner	4a. Facility Name (If not institution, gi				4b. City, Town, o			4c. County		
	C		Washington Adven 5. Social Security Number 6.		oitai . Age (In yrs.	last birthday)	I ak	oma Par		Mont		y place (State or Foreign
	Funeral Director		218-76-1951	1 ☐ M 2 【XF	64	Yrs.	Months Days		Hrs. 8. Date of Birtl Min. (Month, Day March 1	, Year) 5.1940	Nige	ntry)
g	>		Usual Residence of Decedent		10- 03	T						
laryia	shov and at	ក	MD Prince	George's	Toc. Cit	y, Town or Lo Bowie						10d. Inside City Limits 1 1 Yes 2 □ No
the A	28a-1	rect	10e. Street and Number	George 5		DOWLE	10f. Zip Code			10g. Citizen of V	What Cour	
with r	3a or	D	14224 Pleasant	View Dr	ive		207	20		Nigeri		
death	ms 2	Funeral Director	11. Marital Status	12. Was Deced	lent Ever in U	.S. 13.			? (Specify Yes or No- uerto Rican, etc.)		e - Ameri	can Indian,
after	or its	y Fu	1 Never Married 2 Married	1 Tes 2	∑ No	i	1 ⊡Yes 2 🛣 No	Specify:	deno Ficari, etc.)		ck, White, v: B1a	
hours	tural',	ed by	3 XWidowed 4 □ Divorced	Year or Dat								
in 72	n "na	Completed	15. Decedent's I	ade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of	working	16b. Kind of B	usiness/in	austry
d with	giene.	mo	Elementary/Secondary (0-12)	College (1 4	40r 5+)		Teacher			Educat	ion	
3 9	al Hyg	Be C	17. Father's Name (First, Middle, Las	•					Name (First, Middle,		10)	
y id	Ment parked paric e	To	Asogwo Mbosiog						ne Nwadoro			
12 sh	h and 7 Is m Iraum		19a. Informant's Name/Relationship						Rural Route Numbe			
ָם מר	Healt tem 2 other		Ndidi Njaka / da 20a. Method of Disposition	ugnter	20b. F	Place of Dispo	+ Pleasan sition (Name of	1	DI. DOW.	ie, MD.	207	
2298	Department of Health and Mental Hyglene. important: If item 27 is marked other than "natural; or items 23s or 28s-f show important: If item 27 is marked other than "natural partments event; the Medical Examination and the natified at once.		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec				natory or other pla Memoria 1		/05/2005		-	
mit. Pages	partm portal y inju		21. Signature of Funeral Service Lice		10		2. Name and Addre		Beall Fun			
i a	Depa impo any ir once.		Buan	- How	ell	65	E12 NW Cr					0715
recuted (II)	physician and modern and medical the burial-transit	Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listage of the year that initiated events resulting in death) Last	a	r as a conseq	uence of):	eme					Approximate Interval Between Onset and Death
Physicien: The law requires that the death certificate be ex	signed by the attending physici d be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregpant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		th 2 ☐ Feta nt at time of d	Ideath 3	Ectopic pregnanc	1			te of delive	ery Day Year
الم res tha	pe del	by	Part II. Other significant conditions	contributing to dea	ith but not res	ulting in the u	nderlying cause giv	en in Part I.				ne cause of death?
requir	bluods	eted	Hypo	hyers	1 hours				- 1□Y	es 2 Mo	3 Prot	pably 4 □Unknown
The law	has Je 2	Completed							— 24a. Was a autop: perfor	med?	Were auto prior to co death? I 🔲 Yes	psy findings available mpletion of cause of
VICION	certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	/		ott	or	Death (Check only or			
2 g	± ₩	T: To	1 Yes 2 No	28a. Date of		ER/Outpatier 28b. Time of	IL JUDOA	4 [] (AUI 2II I	g Home 5 Resid			y)
	uth. r; After th e funeral	atior	1 Patural 5 Pending 2 Accident investigati		, Day Year)	Injury	Wor	k? Yes 2⊟No				
ai or Atte	s after deat ii Director; ad in by the	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place o	of Injury - At hog, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rura	l Route Number,
to the Hospital or Attending	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ext	hysician: To the base miner: On the base and manner	sis of examina	wledge, death tion and/or in	h occurred at the til vestigation, in my o	ne, date and pl pinion, death o	ace, and due to the coccurred at the time, o	ause(s) and ma late and place,	inner as s and due to	tated. o the cause(s)
o	To t com	Ň	29b. Signature and title of certifier	/ 7	Ton	112	29c. Licens	e number	5	29d. Date signer	d (Month,	Day, Year)
1	3/10		1/2/2/2/2	w/5)	K/	1 22	. 6	111111	I MAG	1/12	12	0113
	700	-	30. Name and address of person who	completed cause	or death (Iten	n Ega) (Type,	Printing 17.	YNdo	The state of the	DIA	14.	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ture	10000	ER I P		. 4		

			State of Maryland / Dep	partment of Health and Mertificate of Death	ental Hygie	UUU UII.I.I.
П			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia /Medic		Rufus Samuel Nedwards		Jan.	11 2005 8:00 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Prince Georges Medical Center	Cheverly		Prince Georges
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 ☑ M 2 ☐ F 81 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yo	
	Director		579-22-2689 Usual Residence of Decedent		May 18 19	23 South Carolina
	/land		10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits
	Mar.	tor	MD Prince Georges Landove	er		1
	or 28	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
	23a	rai	1803 Belle Haven Drive #102	20785		USA
	er deg	Funerai	Armed Forces?	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	hours after death with the Maryland turel', or Items 23a or 28e-f show at Exertiret must be rollited at	by F	1 XNever Married 2 ☐ Married 1 XNes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Black
Maryland 21215-0036	2 hou	led l	15 Decedent's Education 16a Dec	edent's Usual Occupation	16	b. Kind of Business/Industry
215	hin 72 3. 3n "na Medi	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0·12) College (1-4or 5+)	e kind of work done during most of worl DO NOT use retired)	king	
7	er the	Com	12th.	Accountant		.S. Government
2	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	iden Surname)
<u>X</u>	2 should be filed within 72 hours after death with the Marylan n and Mental Hygiene. r ie marked other then "naturel", or Items 23a or 28e-1 show reumetic event, I'm Medical Exertiner must be rollified at	Ţ	Willie Nedwards		Bishop	
a N	d 2 sh h and 7 ie n treun	ı i		ling Address (Street and Number or Rus Gallatin St. N.W.		
	1 and Health em 27		-			c. Location - City or Town, State
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 ie marked any injury or other treumetic er once.		Partial 2 Cremation 3 — Nemoval noni State		_05 Ch	eltenham, MD.
≣	nit. F artme orten injur		Tion y active	Veterans 01–25 22. Name and Address of Facility MAr		
ñ	permit. Departr Importe any inju			4217 9th. St. N.W.		
			23a. Pan . Ever the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest	Approximate Interval Between
	Pnysician	VE 9		CARDIDA	IDIA	Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):	DOWEL O	10/	
6	Examiner .	L	Sequentially list conditions, b. SMALL (DOWEL C	つろられ	MATON
	bed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
•	xecut and al-tran	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
8760	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai E	L _d			
89	ificate g phy as the		<u> </u>			
Box	h cert endin	In/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	☐Ectopic pregnancy		23d. Date of delivery
	s deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5	Other (specify)		Month Day Year
P. 0.	n requires that the death certifit been signed by the attending f should be detached for use as	Physician/Me	a Choukuowu		OG- Didash-	
	signed	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death? 2 No 3 Probably 4 Munknown
000	requi	eted				
Records,	ne taw has b	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
	(0		Of Was associated by a dist		1 Yes 2 🛭	No 1 ☐ Yes 2 ☐ No
Vita	eicie s certi irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient	Othor	th (Check only one)	ee 6 □Other (Specify)
0	Attending Physicien: ir death. ector: After this certifics by the funeral director, I	-	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how	
0	uttending f death. ctor: After y the funer	atio	1 XNatural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
Division of	l or Attencatter death	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	itel o irs aft rel Di					
	Hosp 24 hou Fune felly file	ical	29a. Certifier (Check only (Ch			
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	one) and manner stated. 29b. Signature and title of certifier.	29c. License number	29d.	. Date signed (Month, Day, Year)
	FIFS			MM D 5810.	2_ 1	-11-2005
1/	T OK		30. Name and address of person who completed cause of death (Item 23a) (Typy	a, Print)		
	00			OSPITAL DR	CHEVERL)	Y, MD 20785
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature			1
	Regist	rar	JAN 4 5 2005 Bleen 14 5006			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UUD Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JANUARY 20 <u>2005</u> 8:40 AM POWELL 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3800 Enfield Chase Court # 328 Bowie Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 XM 2 □ F Months 228-26-2795 April 10 1925 Virginia Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3800 Enfield Chase Court # 328 20716 S A 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 2 No 1 Never Married 2 Married XYes Army 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Black. Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government 12th Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Powe11 Nannie E. Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2004 E. Marlboro Avenue Landover, Maryland 20785 Linwood Tyler/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 2/2/05 Cheltenham, Maryland 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Fur eral Service 7474 Landover Road Landover, Maryland 20785 23a. Part Fixer the disease, ir co shock, or he in failure list or r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, conly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronary Artery Disease disease or condition resulting in death) Due to (or as a consequence of): Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Renal Failure that initiated events resulting in death) Last Due to (or as a consequence of):

Physician /Medical Examiner

The law requires that the death certificate be executed

or Attending Physiclen:

signed by

certificate has

After

Director:

Within 24 hours a

filled in by

Medical

Division of Vital Records, P.O. Box 68760,

Examiner attending physician and for use as the burial-transit

For State Registrar

JAMES

10a, State

Physician

/Medical

Examiner

Funeral

Director

ral', or items 23s or 28e-f show Examiner cust be notified at

Director MD

Funeral

þ

Completed

Be

ု့ဝ

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

"natural',

other than

and Mental

Just 1 and 2.

Just the death at Importent: If item 27 is n any injury or other.

Baltimore, Maryland 21215-0036

Physician/Medical å Completed Be Certification: To

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

No

5 Pending

investigation

6 Could not be determined

examiner'

1 Tes

Magner of

Natural Accident

3 Suicide

29a, Certifie

4 | Homicide

9 Unknown

	d
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth

of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

1 Tyes

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? 1 ☐ Yes 2b. No

24b. Were autopsy findings available prior to completion of cause of death?

Year

26. Place of Death (Check Residence 6 Other (Specify) Other:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🗆 Nursing Home 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) (Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one 29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Theresa Allen M.D. 6525 Belcrest Road Suite 160 Hyattsville, Maryland 20782 31. Date filed (Month, Day, Year)

State Registrar

2005



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 01/23/2005 Year 11:45 A **Physician** Divaliben Patel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 5151 Allentown Road Camp Springs If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 10/14/1915 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** 1 ☐ M 2√ XF 89 India 636-42-8188 Director Usual Residence of Decedent Pages 1 and 2 should be titled within 72 hours after death with the Maryland ment of Heatth and Mental Hyglene.

Int. If item 27 Is marked other than "netural", or Items 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show iter owat be notified at 1 ☐ Yes 2 ☐ No Be Completed by Funeral Director Camp Springs Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5151 Allentown Road 20746 INDIA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status item 27 is marked other than "netural", or iten other traumatic event, the Modical Examiner 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. Specify: Asian / % ₩idowed 4 Divorced Indian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) in Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ratanben Patel Morarbhai Patel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5151 Allentown Road Camp Springs, Maryland 20746 / Grandson Pankaj Patel 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial XXXremation 3 Removal from State
4 Donation Other (Specify) 01/25/2005 Edgewater, Maryland Department of Important: If any Injury or once. = 5 Kalas Crematory 22. Name and Address @ 500 Mage P. Kalas Funeral Home PA 21. Signature uneral Service Licenses 6160 Oxon Hill Road Oxon Hill, Maryland 20745 al 23a. Park. Enter the disease, of complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MEART FAILURE Immediate Cause (Final disease or condition resulting in death) CONGESTIVE Pnysician /Medical Due to (or as a consequence of): CARDIOMYORATHY Examiner DILATED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9□ Unknown 9 Unknown ፩ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Jnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has 1 Yes To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 3 Nesidence 6 Other (Specify) 70 1 ☐ Yes 2 No this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Alter Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death, investigation 2 Accident completely filled in by the Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 T Homicide within 24 hours a 1 🚰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medicel iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 5 3 8 8 5 29b. Signature and title of certifi

State Registrar ame and address of person,

ENKAT .

S. KAMAWAN

SURRATIS ROAD

who completed cause of death (Item 23a) (Type, Print)

		1 - State Amend I tem 10 Registrar Amend I tem 1. Decedent's Name (First, Middle, Last		hy G841	'-Cer	tificate of	Death	2, Date of	Death		3. Time of Death
Physici		· ·	seph G.	Porter,	Jr.			Janua	ry 2	Pr, 2005	7:45 A.M
/Medio Examin	ier	4a. Fecility Name (If not institution, give 2819 Sudberry Lane	street and numbe	er)		4b. City, Town, o		Death		4c. County of D	
					t to instruction of	Bowie		4 Hrs 9 Date of		Prince	
uneral irector		5. Social Security Number 6. Se 452-66-2944	X]M 2□F	Age (<i>In yr</i> s. last 64	Yrs.	Months Days	Hours		Day, Yea	ar)	Birthplace (State or Foreig Country) 1inois
>		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation		· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limit
faho	ō	Md. Prince Ge	orges	100. 01.9, 1		Bowie					1 2 Yes 2 □ N
r 28a	Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of What	Country?
23a 0	raiD	2819 Sudberry Lan				2	20715			USA	
id other than "natural", or Itams 23a or 28a-f show event, the Medical Examinat must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Ves 2[If Yes, Give Year or Date:	is?	_ "	Vas Decedent of H Yes, specify Cuba Yes 2x No	lispanic Orig an, Mexican, Specify:	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - A Black, W Specify: W	
natura dical E	Completed	15. Decedent's Edu (Specify only highest grad	ication		6a. Deced	ent's Usual Occup	durina most	of working	16b	. Kind of Busine	ss/Industry
than the Me	iduo	Elementary/Secondary (0-12)	College (1-40	or 5+)		fense coi	,	or	TIC	Gov't.	
other ent,	Be Co	17. Father's Name (First, Middle, Last)	/		De	Tense Co.		's Name (First, Mide			
' is markad other than raumatic event, the M	To B	Jo	seph Geo	orge Por	rter			Naomi	Cath	nerine M	lor1ock
00 2		19a. Informant's Name/Relationship (7)			19b. Mailin	g Address (Street Sudberry	and Number	or Rural Route Nui	nber, Cit	y or Town, State	a, Zip Coda)
Item 27 i		Frances C. Porter	- wife	OOh Dies	- of Diama	niking /klassa si		Bowie, Md	200.)715 Location - City	or Town, State
= 5		1XXBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Mt. (etery, cren Oak M	natory or other plac ethodist	Cem. Churc	01-26-05	Mit	chellvi	11e, Md.
Important: I any injury o once.		21. Signature of Funeral Service Licens			22	. Name and Addre	ss of Facility		nera	1 Home	
		23a. Part1. Enter the disease, or comp. shock, or heart failure. List only o	lications that caus	sed the death. [110 . 20	Approximate Interval Between
sician		Immediate Cause (Final disease or condition	a. Prost	tate (c.	ries		_				Onset and Death
edical miner		resulting in death)	Due to (or	as a consequen	nce of):						
	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequen	nce of):						
ind transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c								
physicien and the burial-transit	dicai Ex	L	d	as a consequen	ice or).						
attending ph	n/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor							23d. Date of	delivery
led by the atte detached for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 ☐ Fetal de t at time of death n		Ectopic pregnancy Other (specify)			-	Month	Day Year
sign d be	by	Part II. Dther significant conditions co	ntributing to deat	h but not resultir	ng in the ur	nderlying cause giv	en in Part I.		d tobaco □ Yes	1/	e to the cause of death? Probably 4 DUnknow
has je 2	Completed								rformed	? prior death	
is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth		of Death (Check on			
this al dii	. To	1 ☐ Yes 2 No 27. Manner of Death	1 🗀 Inpi		VOutpatien Bb. Time of	t 3 DOA 28c. Injur	4 🗀 1901			6 □Other (S	(pecify)
r: After the funeral	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of I (Month,	Day Year)	Injury		k? Yes 2 □ N	lo			
To the Funaral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of building,	Injury - At home etc. (Specify)	e, farm, str	eet, factory, office			n (Street Town, St		Rural Route Number,
To the Funaral Director: completely filled in by the	Medical C	29a. Certifying Phy (Check only one)		s of examination							
To th	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. i	Date signed (Mo	onth, Day, Year)
14)		- Renda a	رهـ			2166	19-11	New York)	20	i~ , 20	1,2005
	11 1	30. Name and address of person who c	ompleted cause of	of death (Item 23	3a) (Type,	Print)		NW Wast		, N	3 3 2 2 2
AC.		Brendan Wess Mi	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Vine A	μ	L 700/100	we . A	A VICTO MINIT	11/4/2	D K	L0331

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 U U 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Lee Porton 18, January 2005 11:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14400 Homecrest Road, #109 Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 N F 218-01-3813 Yrs. Director 94 1, Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show item 27 la marked other than "natural", or Itams 23a or 28e-f sho other traumatic event, It a Madical Examinar must be notified at 1 ☐ Yes 2 📉 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14400 Homecrest Road, #109 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. illed within 72 hours after ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Yes, Give Specify: Completed by Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Woodward & Lothrop Department Store 12 Sales Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fi Department of Health and Mental I-Important: If Item 27 Ia marked of any injury or other traumatic ever any injury or other traumatic ever Be ould be f William Hungerford Lillian Elizabeth Peddicord ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fran Whiteside/ Daughter 1707 Calle Los Vecinos, NW, Albuquerque, NM 87107 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State January 22, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Parklawn Memorial Park 2005 Rockville, Maryland 21. Signature of Funeral Service Licensee Francis of Each line Funeral Home Inc 500 University Elvd, W, Silver Spring, MD 20901 23a. Part1. Enter the please, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fillure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10 Days Intestinal Obstruction /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disass of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of) Records, P.O. Box 68760, attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ξ in the past 12 months? Year Day 5 Other (specify) Yes 2 No detached 9 Unknown is been signed by the should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 XNo of Vital or Attanding Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 XNatural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To tha Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D38262 January 19, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anurita Mendhiratta, M.D. 2401 Research Blvd, #330, Rockville, MD 20852 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2005 Registrar

DHMH 17 Rev 1/2001

121/05-OKPER Weaks (Verwitte)

			For State Registrar	State o	f Maryland		artment of H		d Mental Hy	giene Reg. No. C	11114	03558
	Physicia	an	Decedent's Name (First, Middle WTLLIAM	e, Last) HENRY	PLU	MMER	JR.		2. Date of De Month Januar	Day	Year 2005	3. Time of Death 10:30 A M
	/Medic Examin		4a. Facility Name (If not institution 3026 OAK GREEN	, give street and nu			4b. City, Town, or ELLICO	TT CITY	7	4c. C	ounty of Death HOWARD	
	uneral irector		5. Social Security Number 578-64-9362	6. Sex 1 ∑ M 2□F	7. Age (In yrs. la 54	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	Hrs. 8. Date of Bi (Month, D August	15 19	9. Birth Cou 950 Gre	place (State or Foreign intry) enville,N.(
Aaryland	edat	or	Usual Residence of Decedent 10a. State 10b. County MD Howar	d		, Town or Lo						10d. Inside City Limits 1 ∑Yes 2 □ No
the A	r 28e-	irect	MD Howar 10e. Street and Number	<u>u</u>			10f. Zip Code			10g. Citize	on of What Cou	intry?
th with	23a o	al D	3026 Oakview (Court			21043			U.S.		
within 72 hours after death with the Maryland	ital hygiene. id other than "natural", or lieme 23a or 28e-f ehow event, the Medical Evar ther must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 XDivorced	ried Armed F	2 X No ive	S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin' n, Mexican, Pi Specify:	? (Specify Yes or N uerto Rican, etc.)		I. Race - Amer Black, White Specify: B	
d 2 should be filed within 72 hours aft	n "natural Vedical Ex	Completed b	15. Deceder	it's Education st grade completed,		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of	working	16b. Kind	d of Business/li	ndustry
d with	al Hygiene. other than vent, the Me	E O	Elementary/Secondary (6 12)		yrs		Technicar				rivate	
old be filed	nd Mental Hyg marked othe	To Be C	17. Father's Name (First, Middle, William H. Pl					Dorot	Name (First, Middl hy M. Arn	ingto	n	
2 should	G 00 2	ľ	19a. Informant's Name/Relations				ng Address (Street					
	Health tem 27	10	DOROTHY PLUMMI	ER/SISTER	20h P		Haynes St		Date		ation - City or 3	
ges 1	or off		20a. Method of Disposition 1 Burial 2 Cremation		1 State		osition (Name of matory or other place					
Pa	Department of the important: If ite any injury or of once.		' 4 □ Donation 5 □ Other (\$21. Signature of Fu		Riv		e Cremato 2. Name and Addre	-	/22/05 J. B. J	-		aryland
permit. Pages 1 a	Depar Important any ir once.		21. Signature of Fur	6	/		7474 Land					
	ysician		23a. Part1. Enter the disease, of shock, or heart failure. Lis Immediate Cause (Final disease or condition	t only one cause on	caused the death each line. ver Cirr		ter the mode of dyin	g, such as car	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Medical caminer		resulting in death)	Due to	o (or as a conseq	uence of):						
24		miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to	o (or as a conseq	uence of):						
ate be executed	hysician an the burial-tr	licai Examiner	resulting in death) Last	d	o (or as a conseq	uence of):						
the death certificat	ied by the attending physician and detached to use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live	utcome of pregna birth 2 Teta gnant at time of o	al death 3	□Ectopic pregnanc □ Other (specify) _	/		2	3d. Date of deli Month	very Day Year
- hat	been signed by should be deta	b	Part II. Other significant condit	cions contributing to	death but not res	sulting in the	underlying cause giv	ren in Part I.		i tobacco us		the cause of death?
ne law	has b je 2 sl	Completed							24a. Wt au pe 1 □ Yes	opsy formed?	24b. Were au prior to death?	itopsy findings available completion of cause of
-	certificate ector, pag	0	25. Was case referred to medic	al					Death (Check onl	one)		
OI VILE Physicien:	this certific al director,	To B	examiner? 1 ☐ Yes 2 🔀 No		Inpatient 2	1	ent 3 □ DOA		ing Home 5 Re			cify)
o a fa			27. Manner of Death 1 ⊠Natural 5 □ Pend	iiig	e of Injury onth, Day Year)	28b. Time Injury	Wo	ryat rk?]Yes 2.⊟No	28d. Describ	e how injury	occurred	
or Attending Phy	att	Certification;	3 Suicide 6 Coul	minod 200. Fld	ce of Injury - At h Iding, etc. (Speci	nome, farm, s ify)	M 1 _	163 2 110	28f. Location	(Street and own, State)	i Number or Ru	ural Route Number,
Hospitei	Funerel Funerel tely filled	ledical Ce	29a. Certifier 1 Certify (Check only one) 2 Medica	ring Physician: To the land many many many many many many many many	he best of my kn basis of examination	owledge, de ation and/or	ath occurred at the ti investigation, in my	me, date and opinion, death	place, and due to the occurred at the time	e cause(s) e, date and	and manner as place, and due	stated. to the cause(s)
To the	within domple	Me	29b. Signature and title of certif	ier			29c. Licen	re number			signed (Mont	_
(136		30. Name and add as of person Dr. Jarrah Rafic				e, Print)			20017		
	S Regis	tate trar	31. Date filed (Month Day Yes		. Registrar's Sig							

			1 - For State Ragistrar	State of M	aryland / Dep <i>Ce</i>	artment of F		Mental Hy	giene	0.0	
			Decedent's Name (First, Middle, Last)					2. Date of De	ath 100	UU5	3 Time of Death
	Physici		Patricia E. Parri	sh				Januar	Day 21.	2005	11:45A M
	/Medi Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Deatl			ounty of Death	11:4511
	LAGITIII	ic.	Gilchrist Hospice			Towson				timore	
	Funeral		5. Social Security Number 6. Sex	7. Ag	ge (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birthi	place (State or Foreign
	Director		148-28-3887	M 20XF	68 Yrs.	Months Days	Hours Min.	Dec. 1	19, Year) 19	Cou	sachusetts
	D		Usual Residence of Decedent								
	how		10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	B Ma	cto	Maryland Howard		Columbia						1 ☐ Yes 2 🛣 No
	17 th	Director	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cou	ntry?
	23a	ai	6238 Ironwood Way			21045			USA		
	ams erri	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (S	pecity Yes or No	- 14.	Race - America	
9	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or items 23e or 28e-f show that the Medical Exercities must be rodified at	Y FL	1 Never Married 2X Married	1 ☐ Yes 2 🔀 If Yes, Give	No	1 ☐ Yes 2 🗓 No				naoih <i>e</i>	
21215-0036	ural',	d by	3 Widowed 4 Divorced	Year or Dates:						Whit	te
7	nat alic	Completed	15. Decedent's Edu (Specify only highest grade	cation com <i>pleted)</i>	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor	rking	16b. Kind	of Business/In	dustry
121	withir ne.	ш	Elementary/Secondary (0-12)	College (1-4or	5+)		a)		_	7	
2	lled v lygie her t		17. Father's Name (First, Middle, Last)	4	Trav	el Agent	18. Mother's Nan	no /First Middle	Trav		
Maryland	2 should be filed within and Mental Hygiene. Is marked othar than aumatic avsnt, II e M	Be							, Maideri Su	imame/	
Z	should ind Men	L _O	John Hanley Murphy 19a. Informant's Name/Relationship (Ty		10h Mail	in a Address (Street	Mariam I		O'tT		0-7-1
Ma	h and	7 9		•		ing Address (Street				· ·	Code)
	1 and 3 Health tem 27 other tra	1	Leon L. Parrish/hu	sband	20b. Place of Disp	Ironwood				45 tion - City or To	our State
ō	Pages nent of I int: If its		1 ☐ Burial 2 X Cremation 3 ☐ R	emoval from State	cemetery, cre	matory or other plac		lary 22			
Ë	tmen tant tant		'4 □ Donation 5 □ Other (Specify)	0		el Cremat	1			on, Mar	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inportant: if item 27 is marked other than "natural", or items 23e or 28e-f show amportant: or other traumatic event, if a Medical Exp. if at must be routilled at QDCs.		21. Signature of Funeral Service License Servery L. Her	Ett		2. Name and Addre Ding Home everly L.					784 e, MD 21029
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that cause le cause on each I	d the death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Pnysician	2 1	Immediate Cause (Final disease or condition	m	Labor	lie, e	neep	halos	VATE	- II	Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of):	C .	1	-			a cerci
	Examiner		Sequentially list conditions	1	enal	Jack	nere				year
	- =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		a consequence of).		WW. I	4			
	xecuter and Il-trans	Examiner	Cause (Disease or injury that initiated events	U	- wet	- M	المنالية	Lan			hear
Ó,	The law requires that the death certificate be executed te has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	EX	resulting in death) Last	Due or as	a consequence of):					/	1
8760,	sate be ex hysician the buria	dicai								- (
9	ntifica ing pt	0	IF FEMALE:						1		
Вох	eath certific attending p	Physician/M	23b. Was decedent pregnant	3c. If yes, outcome 1☐Live birth		□Ectopic pregnancy	,		230	f. Date of delive	•
	ne dea the at hed fo	sici	in the past 12 months?	4□Pregnant a 9□ Unknown	t time of death 5 (Other (specify)				Month	Day Year
P.0	that the de ed by the detached	Phy	9 Unknowh					1			
	rires tha signed d be det	by	Part II. Other significant conditions con	tributing to death t	out not resulting in the u	inderlying cause giv	en in Part I.		(%)	l. I	he cause of death?
ord	w requir been s should	ted	typuters	en				10`	Yes 2D	o 3 Prob	pably 4 ∐Unknown
Records,	e law r has be je 2 sh	Completed	Wult se	Str	UKes			24a. Was		4b. Were auto	psy findings available
æ		OT	J					perfo	rmed? 2A No	death? 1 ☐ Yes	mpletion of cause of
Vital	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o			
of V	ys Sis	2	1 ☐ Yes 2 No	ospital: 1 🔲 Inpati	ent 2 ER/Outpatie	nt 3 DOA Oth	er: 4 ☐ Nursing H	ome 5 Resid	dence 6	Other (Specif	n/forepers
			27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju	ury 28b. Time o	of 28c. Injur Wor	y at k?	28d. Describe h	now injury o	ccurred	
<u>Ö</u>	' Attsnding Ph ar death. ractor: After th by the funeral	atic	2 Accident investigation				Yes 2 □ No				
Division	r Att	tiffe	3 Suicide 6 Could not be determined	28e. Place of In	jury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (S City or Tox	Street and N	lumber or Rura	Il Route Number,
	ital o	Certification:									
	To the Hospital or Attanding within 24 hours after death. To the Funaral Director; After completely filled in by the fune.	Medical	29a. Centiner (Check only one) Cartifying Phys	ier: On the basis of	or my knowledge, deal of examination and/or in	n occurred at the tin evestigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) an date and pla	d manner as si	tated. o the cause(s)
	thin thin the mple	Mec	29b. Signature and title of certifier	and manner st	ateu.	29c. Licens	e number		29d, Date e	igned (Month,	Day Year!
	F F F 8		1/1/1/1		0	_		1	_	-	*
			11/1/1/1	7 Rue	y will	102	و سر		177	VAKY	21,000
12	,		30. Name and address of person who co	moleted cause of	Type,	Print)	- Char	les St	8-0	los 1	21,2005
	- 04		31. Date filed (Month, Day, Year)	32. Registr	rar's Signature	9(01)			(0	-, , , , , ,	4
	Sta Registi		JAN 2 5 20	05	va & d	Soull)					

Physician Medical Examiner 4a. Facility Name (If not institution, give street and number) 2015 Border Drive 4a. Facility Name (If not institution, give street and number) 2015 Border Drive 4a. Facility Name (If not institution, give street and number) 2015 Border Drive 4a. Facility Name (If not institution, give street and number) 2015 Border Drive 4a. Facility Name (If not institution, give street and number) 4b. Use The Washington 4c. County of Death Frince George's Frince George's 9. Bigmanage (State or Fe Toward 10a. State 10b. County 10c. City, Town or Location Maryland Prince George's 10b. State 10b. County 10c. City, Town or Location Maryland Prince George's 10c. State 10b. County 10c. City, Town or Location Maryland Prince George's 10b. State 10b. County 10c. City, Town or Location Maryland Prince George's 10c. State 10b. County 10c. Institution 10c. I		1 - For State Registrar		epartment of Health and Certificate of Death	Reg.	ne No2005	0356
So Social Source Number So Social Source Number Social Soc	/Medical	FRANK 4a. Facility Name (If not institution,	give street and number)	4b. City, Town, or Location of Dea	Month 1 2	4c. County of Death	3. Time of Death 2:30P
104. State 105. County Prince George 105. County 105. Coun		482-28-2053		day) If Under 1 Year If Under 24 Hr			ace (State or Fore
23a/Part Enfect the disease for complication in that caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest. Approximate finite rail Barves and the conditions of the conditi	diffed at	10a. State 10b. County Maryland Prince				10	od. Inside City Lim
Can Part Inter the disease for complication in that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate finite products of the product of the pr	uniber al Dire		ive	· ·	10g.		ry?
23a Fant. Enter the disease for complications (that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Sequentially list conditions, a purpose of the conditions of the conditions of the conditions of the conditions. Sequentially list conditions, a purpose of the conditions of the condition	Exactor on by Funer	1 ☐ Never Married 2 ☼ Marrie	Armed Forces? XXYes 2 No 1950-		Specify Yes or No- rto Rican, etc.)	Black, White, e	itc.
23a Part Letter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate finitive List only one calse on each line.	In Medical	(Specify onfy highest					ŕ
23a Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cayles to each line. Indicate a case of continuous contributions of the case of continuous contributions of the case of continuous contributions. Sequentially list conditions, show the case of continuous contributions of the case of continuous contributions. Sequentially list conditions, show the case of continuous contributions of the case of c	To Be Co	A 1 1 . TO 1	ist)	18. Mother's Na		den Sumame)	
23a Part Letter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate finite products and products are consistent or conditions and products are consistent or conditions. Conditions and products are consistent or conditions.	er treum						
23a Part Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cargles on each line. Part of the disease of conditions and the death of the mode of dying, such as cardiac or respiratory arrest. Approximate interval Balves conditions and the death of the mode of dying, such as cardiac or respiratory arrest. Approximate interval Balves conditions and the death of the mode of dying, such as cardiac or respiratory arrest. Approximate interval Balves conditions and the death of the mode of dying, such as cardiac or respiratory arrest. Approximate interval Balves conditions and the mode of dying, such as cardiac or respiratory arrest. Approximate interval Balves conditions and the mode of dying, such as cardiac or respiratory arrest. Approximate interval Balves conditions. Approximate interval Balves conditions. But to display the display of the death of the death of the cardiac cardiac cardiac or respiratory arrest. Approximate interval Balves conditions. Due to (or as a consequence of): Due	uny or our	1 ☐ Burial 2 🖔 Fremation 3	Undilloval holli State Value C	Crematory 01/	22/2005 E	dgewater, M	Maryland
Interest Cause (Final death) Cause (Fi	any inj	DAR 6.14	alos 1	OTOO OXOH HITTI KC	ad OXOII III.	ri, Maryiai	id 20/45
Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a	edical miner	Immediate Cause (Final disease or condition resulting in death)	a. CIRRHESIS Due to (or as a consequence of) b. ALLOHOL	ARUSE L		21	Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death of the conditions contributed to the cause of death of the conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death of the cause of	cal	cause (chease of injuly that initiated events resulting in death) Last	c	:			
24a. Was an autopsy performed? 1 Yes 24b. Were autopsy findings availy death? 1 Yes 24b. Were autopsy performed? 1 Yes 24b. Were autopsy findings availy death? 1 Yes 24b. Were autopsy findings a	ched for use as	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death				
25. Was case referred to medical examiner? 25. Was not referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death Nursing Home St. Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 28e. Place of Injury At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		Part II. Other significant condition	s contributing to death but not resulting in the	he underlying cause given in Part I.			
The second of th	page 2				autopsv	prior to com	pletion of cause
27. Manner of Death 1	P C	examiner? 1 ☐ Yes 2XXVo	I Inpatient 2 ER/Outp	atient 3 DOA Other: 4 Nursing		e 6 ☐ Other (Specify))
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	fter iner	1 Natural 5 Pending 2 Accident investiga	tion	M 1 ☐ Yes 2 ☐ No			
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	lled in by	4 Homicide determin	ed 289. Place of Injury - At nome, farm building, etc. (Specify)		City or Town, S	tate)	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) TAWAY Z), ZE	une oly fi	(Check only 2 Medicel E:	ceminer: On the basis of examination and/	or investigation, in my opinion, death occ	curred at the time, date	and place, and due to	the cause(s)
	The Property			29c. License number	29d.	Date signed (Month, D	lay, Year)

			. For	State of Maryl				•	iene	pro-
			1 - State Registrar		Ce	rtificate of	Death	Re	19. No. 200	5 03561
	Physicia	an	Decedent's Name (First, Middle, La	st)				2. Date of Deat Month	Day Yea	3. Time of Death
	/Medic	al	Maria L. Rosales 4a. Facility Name (If not institution, giv	us attend and aumber)		41. Cir. T	-1		19, 2005	12:00 A ^M
	Examin	er	Shady Grove Nursi		itation		or Location of Dea	tn	4c. County of De	
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birthday)	Rockvil If Under 1 Year	If Under 24 Hrs		Montgome 9. B	TY irthplace (State or Foreign Country)
	Director		220-64-0652	1□M 2 X)F	81 Yrs.	Months Days	Hours Min	02/09/19	200	atemala
	and *		Usuat Residence of Decedent 10a. State 10b. County	10c	: City, Town or Lo	ocation				10d. Inside City Limits
	Manyi faho	tor	MD Montgome		Germantov					1 ☐ Yes 2 X No
	r 28a	irec	10e. Street and Number	-19	CIMATICO	10f. Zip Code		10	Og. Citizen of What (Country?
	death with the Maryland ms 23a or 28a-1 ahow r must be notified at	Funeral Director	20841 Scottsbury	Drive		20876		-	U.S.A.	
	r dea	Iner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of I	Hispanic Origin? (San, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - An Black, Wi	nerican Indian,
9	rs arre	by Fi	1 ⚠ Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🐧 No If Yes, Give Year or Dates:		1 X Yes 2 □ No	Specify:	_	Specify:	
2-003p	atura cal E	ted t	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	pation	atemala	16b. Kind of Busines	ispanic s/Industry
ב ב	Madi	Completed	(Specify only highest gra Etementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wo d)	orking		
V	ygien ygien ver th	Con	6		Home	emaker			Own Home	
yland	avan	Be	17. Father's Name (First, Middle, Last)				me (First, Middle, N	,	
	d Mer marke	To	Luis Roy 19a. Informant's Name/Relationship (Type Print!	10h Madi	ng Addrage /Street		ca Rosale	S City or Town, State	To Code
2	tth an		Maria Orozco, Gra							yland 20876
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maylan Department of Health and Mental Hygiene. Inpopurant: If them 27 is marked other then "natural; or items 23a or 28a-1 show any injury or other traumatic avant, the Madical Examiner must be notified at Once.		20a. Method of Disposition	20	b. Place of Dispo				20c. Location - City of	
baltimore,	Page nent c ant: If ary or		1 ∯Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removat from State (y)				/21/2005	Falls Chu	rch, Virginia
	epartr epartr porty ny inje		21. Signatore of Funeral Service tites	nsee	22	2. Name and Addre	ess of Facility S	imple Tri	bute	•
	80588		Cem Synn La	och- strody						land 20852
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each tine.			ng, such as cardia	ic or respiratory arre	st,	Approximate Interval Between Onset and Death
F	hysician /Medical		disease or condition resulting in death)	a. Due to (or as a con	everas	ua				
ı	Examiner			. Due to to to as a con	isequence or,					
	D #	ner	Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con	nsequence of):					
	and and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c					- ,	
5	ate be executed hysicien and the burial-transit	cal E	loosing in county and	Due to (or as a con	isequence or):					
08/00,	certificate iding phys			_ d						
×	w requires that the death certifica been signed by the attending ph should be detached for use as the	by Physician/Med	tF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		7-			23d. Date of d	elivery
ַ	death ne atten ed for u	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown		Ectopic pregnanc Other (specify) _	у		Month	Day Year
5	d by the	Phy	9 Unknown							
ds,	requires that the leen signed by th hould be detache		Part II. Dther significant conditions		SCV 20		en in Part I.			to the cause of death?
000	been been shouic	Completed		1101 30	0116					Probably 4 ⊡Unknown
ě	Ine iaw ate has b page 2 sl	mp						24a. Was ar autopsy perform	prior to	autopsy findings available completion of cause of
Vital	ifficate or, pa	e Co	25. Was case referred to medicat				26 Place of De	1 ☐ Yes 2	2 No 1□Ye	s 2□No
5	ysicii is ceri direct	To B	examiner? 1 □ Yes 2 □ ₩0	Hospitat:	2 ER/Outpatier	nt 3□ DOA Ott		ath (Check only one Home 5 ☐ Reside	nce 6 Other (Sp	ecity)
5	ng Ph ter th		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o		ry at	28d. Describe ho		55.147
VISION	eeth. or: Al	catic	2 Accident investigatio	in .		M 1	Yes 2 □No			
	or Att	Certification;	3 Suicide 6 Could not be determined		At home, farm, str becify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or F State)	Rural Route Number,
_	spitel ours a naral I		29a. Certifier 1 Certifying Pi	hysician: To the best of my	knowledge deat	h occurred at the tr	me date and place	and due to the se	una/a) and mana-a	
:	To the Hospital of Attanding Prysicient. The law within 24 hours after deeth. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2:	edical	(Check only 2 Medical Examone)	miner: On the basis of exar and manner stated.	mination and/or in	vestigation, in my	opinion, death occ	urred at the time, da	te and place, and du	ie to the cause(s)
	withir To th	Ž	29b. Signature and title of certifier		1.4	29c. Licens	se number	29	d. Date signed (Mor	nth, Day, Year)
	3		200	12	(M)	3	8597		19110	05
	,		30. Name and address of person who	completed cause of death	(Item 23a) (Type.	Print) 860	me by CP	Ave. Suij	c 404B	
	Sta	to.	31. Date filed (Month, Day, Year)	32#Registrar's S	ignature /	Print) 860 SIV	~ SDC:Ve	2. MD 7	0910	
	Registr		IAN 2 1 2	005 House	J. 60	ww	1			

			For State Registrar	State o	f Maryla		ertificate of I		d Mental	Hygier	20	05	03	562
	Physicia /Medic		1. Decedent's Name (First, Middle PEGGY	, Last)	120	3315			2. Date of Month		Day Za	Year	3. Time o	
•	Examin		4a. Facility Name (If not institution, Suburban Hospi	-	mber)		4b. City, Town, or Bethes					of Death	ry	
	Funeral Director		5. Social Security Number 218 66 6412	6. Sex 1 ☐ M 2 🕱 F	7. Age (In y	rs. last birthda Yrs.	Months Days	If Under 24 I Hours A	Min. B. Date of (Month)	f Birth Day, Yea 17 1	936	9. Birthp Cout V 1	lace (State of try) rgini	o <i>r Foreign</i> a
	ryland		Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town or			,			1	0d. Inside C	City Limits
	ath with the Marylan 23e or 28e-f show	irecto	10e. Street and Number	tgomery		Silver	S pring			10g.	Citizen of V		ntry?	
	death wil	neral D	4200 Garrett P	ark Road 12. Was Dec		n U.S. 13	. Was Decedent of H	20906		or No-			an Indian,	
980	ours after	by Fu	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced		210/No ve		1 ☐ Yes 2 DXNo	Specify:			Specify	r:	Whit	e
21215-0036	Lail y idility Z IZ ID-DODO 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or iteme 23e or 28e-f show eumatic event, the Madical Exprediter rust be multiput at	Completed by Funeral Director	15. Decedent (Specify only highes Elementary/Secondary (0-12)		1-4or 5+)	(Gin	edent's Usual Occup re kind of work done DO NOT use retired S Aide	ation during most of d)	working		Kind of Bu			
	id be filed ental Hygin ked other ic event, II	To Be Co	17. Father's Name (First, Middle, Worley Rober			1		18. Mother's Ruby	Name (First, M.	ddle, Maid				
	INIGITY 1d 2 shou Ith and M 27 is mar r treumat	-	19a. Informant's Name/Relations! James E. Rossi		ınd	19b. Ma 420	olling Address (Street O Garrett	and Number o	r Rural Route N Road, Si	_{umber, Cit} 1ver	s or Town, Sprii	State, Zip	Code) Id. 20	906
	Dartillore, Dermit. Pages 1 ar Department of Hea mportent: if item: any injury or-other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State		position (Name of ematory or other place) n Cemeter		Date . /25/05		Location -			
<u>:</u>	Datilliofe, Mal yial parmit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury gr-other treumatic e once.		21. Signature of Funeral Service		he		22. Name and Addre	ss of Facility		eral H	lome			
•	Fnysician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	_ a Ac	ate h	death. Do not e	nter the mode of dyir	ng, such as car	diac or respirat	ory arrest,			Approxima Interval Be Onset and	ite atween Death
	Examiner	ē	Sequentially list conditions, if any, leading to immediate	b	`	sequence of):						+		
	6 / OU, sate be executed bhysician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to	(or as a con	sequence of):								
12005	Ords, P.O. BOX 08 requires that the death certificat een signed by the attending phy hould be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		birth 2 □ I nant at time	Fetal death	B □Ectopic pregnanc; 5 □ Other <i>(specify)</i> □	/			23d. Dat Mo	te of deliv	ery Day	Year
0/2	uires that the signed by	þ	Part II. Other significant conditions PREMSE CANCE	ons contributing to c	leath but not	resulting in the	underlying cause giv	ven in Part I.	23e.	Did tobaco 1 □ Yes			he cause of pably 4 🗷	
	as b	Completed			- <u>-</u>					Was an autopsy performed	?_ 5	Were auto prior to co death? I Yes	ppsy findings impletion of 2 \square No	s available cause of
	Or VIKAL P Physicien: Th rthis certificate ral director, pag	To Be (25. Was case referred to medical examiner? 1 \(\text{Yes} \) Yes	11	Inpatient	2 ☐ ER/Outpat	ient 3□ DOA Oth		Death (Check ong Home 5		e 6 □Oth	er (Speci	(y)	
_	VISION OT Attending Physic death. ector: After this by the funeral di	100	27. Manner of Death 1 SNatural 5 Pendir 2 Accident investi		of Injury oth, Day Yea	28b. Time Injur	/ Wo	ry at rk? Yes 2 □ No	28d. Desc	ribe how in	njury occurr	red		
Russie,	DIVISION of or Attending ofter death. I Director: After d in by the func	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 486, Plac	e of Injury ding, etc. (Sp	At home, farm, pecify)	street, factory, office			ion (Street or Town, St		er or Run	al Route Nui	mber,
8	To the Hospitel or Attending Physicien: The within 24 hours effer death. To the Funeral Director: Affer this certificate he completely filled in by the funeral director, page	Medical (29a. Certifier 1 Certifyir (Check only one) 1 Medical	Examiner: On the I	e best of my basis of exam nner stated.	knowledge, demination and/or	ath occurred at the ti- investigation, in my o	me, date and popinion, death	place, and due to occurred at the	the cause time, date	e(s) and ma and place,	anner as s and due t	tated. o the cause	(s)
		Me	29b. Signature and title of certifie	homo			29c. Licens	2967	5	29d. ال	Date signed	d (Month,	Day, Year)	
	8		30. Name and address of person	accia las	0 6	420 R	2901/10/6	2	BeTH	5 DA	Mī)		
	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 24	2005	Registrar's S		reli			/				

	arry Ed 5 - 0550	wai	rd Rosengrant Please T	ype or Print in Black	Indelible Ink.	. Ensure A	All Copies	Are Legib	le.
R	PD		1- For amend item 11 Registrar	State of Maryland / D & 19a per info,	epartment of L Certificate of	lealth and I Death	Mental Hyo	giene Reg. No 20	5 03563
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Dea January		3. Time of Death
	/Medic		Larry Edward		45 Ch Town				
	Examin	er	4a. Facility Name (If not institution, give s 141 Cove Point Roa	.d	Lusby	r Location of Death		4c. County of Calver	t
	Funeral Director		5. Social Security Number 098-42-6799 Usual Residence of Decedent	314 000	Months Days	Hours Min.	8. Date of Birtl (Month, Day March	10 1949	9. Birthplace (State or Foreign Country) Pennslyvania
	Maryland f show	ō	10a. State 10b. County Maryland Calver	10c. City, Town Lust					10d. Inside City Limits 1 ☐ Yes 2X No
	r 28a	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of Wh	at Country?
	h with		11460 Little Co	ve Point Road	2065	7		United	States
	ams ams	Funerai	11, Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Black.	American Indian, White, etc.
900	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If itam 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic event, the Medical Exacultarization inclined at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed Y Divorced	1 ∐Yes 2 ∑XNo If Yes, Give Year or Dates:	1 ☐ Yes 2 🕱 No	Specify:		1	white
21215-0036	ithin 72 h ie. ian "natu i Meolici	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	e completed) (College (1-4or 5+)	Decedent's Usual Occup 'Give kind of work done life. DO NOT use retire	during most of wor d)		16b. Kind of Busi	ness/Industry
	led w tygier her th		1 2	5+ env	vironmenta			EPA Maiden Sumame)	
Maryland	12 should be filed within h and Mental Hygiene. 7 Is markad other than " traumatic evant, the Mes	To Be	Warren E R	cosengrant		Beti	ty Thel	ma Davi	.s
	and 2 sh saith and n 27 is m		19a. Informant's Name/Relationship (Ty Diana Rosengran	it- wife 114			Pt. Rd.	Lusby,	MD 20657
Baltimore,	Pages 1 nent of He int: If itar		20a. Method of Disposition 1 Burial 2 XCremation 3 F 4 Donation 5 Other (Specify)		Disposition (Name of crematory or other place politan I	Jan 29 Juneral	Servic	e Alexand	ty or Town, State
Balti	permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or othar tra <u>once</u> .		21. Signature of Funeral Service Licens	99	22. Name and Addre	ss of Facility	Rausch F	uneral Hom	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death. Do no	4405 Broomes] of enter the mode of dying	ng, such as cardiac	or respiratory an	rest,	Approximate Interval Between
	Pnysician /Medical	ľ	Immediate Cause (Final disease or condition resulting in death)	a. HIPELTENSIVE Due to (or as a consequence of		CLEROTIC	_		Onset and Death
	Examiner		Sequentially list conditions	o			ISEASE		
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	f):				
	xecuted and	xamin	that initiated events resulting in death) Last	Due to (or as a consequence of	f):				
68760,	eath certificate be exattending physician for use as the buria	fical E	L.	1					
9 x	entific ding p	/Mec	IF FEMALE:	23c. If yes, outcome of pregnancy					
P.O. Box	The law requires that the death certificate be enate has been signed by the attending physician page 2 should be detached for use as the burial	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)	у		23d. Date of Month	
	uires that the de signed by the d be detached	y Ph	Part II. Other significant conditions con	ntributing to death but not resulting in	the underlying cause giv	ven in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
rds	w requires been sign should be	ed by					1 🗆 Y	es 2□No 3	Probably 4 nknown
Records,	aw re	Completed					24a. Was a	an 24b. We	ere autopsy findings available or to completion of cause of
- B		Com					perfor 12 Yes	med? dea	ath? ⊈Yes 2□ No
Vital	ysician: Is certific director,	Be	25. Was case referred to medical examiner?	Janaisal.			ath (Check only o		
of		<u>2</u> :	1. Yes 2 □ No 27. Manner of Death	lospital: 1 Inpatient 2 ER/Out	patient 3 DOA			ence 6X Other	(Specify) At Scene
on	Jing After fune	tion	1 Natural 5 Pending 2 Accident investigation		jury Woi		200. 0000110011	ow injury occurred	
Division	or Attandii after death. Diractor: A in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fame building, etc. (Specify)	m, street, factory, office		28f. Location (S City or Tow		or Rural Route Number,
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Medical Co		sician: To the best of my knowledge, ner: On the basis of examination and and manner stated.					
	o tha o the omple	Mec	29b. Signature and title of certifier	and mainlet stated.	29c. Licens	se number	2	29d. Date signed (Month, Day, Year)
	⊬ ≯ ⊢ ŏ		▶ anetz		O.C.M	.E.	J	anuary 23	3, 2005
_	20		30. Name and address of person who or	10, HD 111	Penn Stree	t, Baltin	more, Man	ryland 21	1201
	Sta Regist		31. Date filed (Month, Day, Year) JAN 2	32. Registrates Signature 6 2005	y Sparke				

Julia Pearl Sweene Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-00599 1- State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Reg. No. Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2005 JULIA PEARL SWEENE 10"26 AM January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Allegany Frostburg 56 West. Mechanic Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2XQX Months Days Director 212 24 1872 77 Yrs. APRIL 29 1927 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show event, the Medical Examiner must be nutified at 1 X Yes 2 No Director MARYLAND FROSTBURG ALLEGANY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 WEST MAIN STREET or Items 23e 21532 U.S. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ [X]No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify 3 XWidowed 4 ☐ Divorced urel', WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 'n (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ss 1 and 2 should be fi of Health and Mental H item 27 le marked otl RICHARD ALBERT WATKINS KATHERINE WESLOW 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA C. NELSON / DAUGHTER 12022 BAYER DRIVE, SMITHSBURG, MD 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 🔀 Burial 2 □ Cremation 3 □ Removal from State RESTLAWN MEMORIAL GARDENS !/27/05 LaVALE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 60 W. MAIN STREET SOWERS FUNERAL HOME, P.A. FROSTBURG, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lorazepam intoxication complicated by hypothermia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence oi). Examine iding physician and use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy for Day Month Year 4☐ Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached the 9 Unknown ed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign. I be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Lanknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an autopsy performed? 2 No 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 XYes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6X Other (Specify) SCENE 7 this 28d. Describe how injury occurred
deceased took drugs and was
exposed to cold environmental
the property of th 28a. Date of Injury Fo(1911dh, Day Year) 1-24-05 27. Manner of Death 28h Time of 28c. Injury at Work? Certification: After Found 10:24 a^M 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 📆 No 2 Accident Director: 6 X Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

found in vehicle filled in by 4 Homicide hours after Frostburg, Maryland within 24 hours a To the Funerel (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 egistrar's Signature

EB 07 2005

Registrar DHMH 17 Rev 1/2001 29c. License number OCME

29d. Date signed (Month. Dav. Year)

January 25, 2005

111 Penn Street, Baltimore, Maryland 21201

Frederick Sadler

		For Stata Registrar	Please	Type or P State of		d / Depa	rtment o	f He	ealth and I		•		_	· · ·	
Physiciar /Medica		1. Decedent's Nam	ne (First, Middle, Las		LER, SR		tificate o	or L	<i>leath</i>		Date of D Month		o. <u>Z U U ;</u> ay Year 2005	3. Time	м
Examine	r	4a. Facility Name	If not institution, give Health	street and num Care -	ber)	Pines	Ea If Under 1 Ye	st	ocation of Deatl	h	Date of B	idh	c. County of Dea	ot ot	te or Foreign
Director		220-34-9 Usual Residence of	//13	ex XM 2□F	74	Yrs.	Months Da	ays	Hours Min.		(Month, D PRIL	av. Year	1930 M	ARYLAN	D City Limits
eath with the Marylan is 23a or 28a-f show must be notified at	Director	MD 10e. Street and No	TALBO	T		TILGE		de				10g. C	itizen of What C	XX	′es 2 □ No
or Item	<u>a</u>	11. Marital Status 1 ☐ Never Mar	ried 2 Married	12. Was Deced Armed Ford 1 X Yes 2 If Yes, Give Year or Da	ces? 2 □ No				panic Origin? (S , Mexican, Puert	pecify to Rica	Yes or Nan, etc.)	0-	USA 14. Race - Am Black, Whi	erican Indiar	
c * 3 1 3	Completed	(Spe	15. Decedent's Ecify only highest gra	ducation de completed) College (1-		(Give . life. [OO NOT use re	one du tired)	uring most of wor	rking		16b. I	Kind of Business	·	
be fill H d oth	o ge Co	11 17. Father's Name GUSTAV	(First, Middle, Last)	0		WI	TERMAN		18. Mother's Nar			e, Maide	SEAFOOD n Sumame)		
of Health and I sho of Health and I item 27 is me			R. SADLER		20b. P	PO	-	4 7	nd Number or Ru TILGHMAN		\bigcirc 21	671	or Town, State,		
permit. Pages Department of I Importent: If it any injury or o		1 😾 Burial 2	Cremation 3 5 Other (Specificuneral Service Licer	y)	tate ce	emetery, cren LGHMAN	MEMORI.	place AL	CEM 1-2 of Facility ELFENBEI			TI	LGHMAN,	MARYI	LAND
Physician /Medical Examiner Inial-Itansii	ledical Examiner	shock, or he Immediate Cause disease or condit resulting in death. Sequentially list of if any, leading to it any, leading to cause. End thin Cause (Disease o that initiated even resulting in death)	onditions, mmediate	a	used the death ch line. OUM 974 or as a consequence as	uence of): uence of): uence of):			RISON ST, such as cardiac				21601	Approxii Interval Onset a	Between nd Death
ithat the death cert ed by the attendin detached for use	Physician/Medica	IF FEMALE: 23b. Was decede in the past 1: 1 Yes 2 9 Unknow	2 months?		rth 2 ☐ Fetal int at time of de	death 3	Ectopic pregna Other (specify						23d. Date of de Month	livery Day	Year
igne igne be c	2	Part II. Other sign	ificant conditions o	ontributing to dea	ath but not resu	ulting in the ur	nderlying cause	givei	n in Part I.			tobacco Yes 2	use contribute t		of death?
The ate h	Completed	25. Was case refe	arred to medical						26. Place of Dea	1000	perf 1 Tes	opsy formed? 20 N	death?	completion	gs available of cause of
hye his I dii	Certification: To Be	examiner?	No	28a. Date o (Month	f Injury 7, Day Year)	ER/Outpatien 28b. Time of Injury	28c. I	Other	r: 4 Nursing H	lome 28d	5 🗌 Res	idence how inju	6 Other (Speury occurred		
e Hospitel or Attending 24 hours atter death. E Lunerel Director: Atter letely filled in by the fune		4 ☐ Homicide	dotominod	buildin	of Injury - At ho g, etc. (Specify				a date and place		City or To	own, Stat			lumber,
E 2 E G	Medical	(Check only one) 29b. Signature an	2 Medical Exar		sis of examinat		estigation, in r	ny opi				, date ar		e to the caus	
		30. Name and add	dress of person who	completed cause	o death (Item	23a) (Type,	Print)	Á	VENIV.		EA	STA	M MA	210	001
State Registra	-	31. Date filed.(M	7"2"6 2005	32. Re	egistrar's Signa	ture	· WIND	1/.	VUIVE		~1	<i>-1</i> ()	, , , , , , , , , , , , , , , , , , ,	S/V	, ~ [

ORIGINAL

			1 - State Amend Item 25	State of Marylan per me G841 3				•	_	5 0356
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	Shreuz				2. Date of Death Month		3. Time of Death P
	/Medic Examin		4a. Facility Name (If not institution, give si	treet and number)			Location of Death		4c. County of Dea	th
	Funeral Director		UNIVERSITY OF MARY 5. Social Security Number 6. Sex 217-24-0991	LAND 7. Age (In yrs. I 7. 75	ast birthday) Yrs.	BAL If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,		thplace (State or Foreign ountry)
Ī	death with the Maryland ms 23a or 28e-f show	tor	Usual Residence of Decedent 10a. State 10b. County MD TALBO		r, Town or Lo					10d. Inside City Limits X Yes 2 No
	or 28e	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	leath v	Funeral	5483 RUDE AVE.	2. Was Decedent Ever in U.	S. 13. 1		671 Ispanic Origin? (Spec In, Mexican, Puerto R	ify Yes or No-	USA. 14. Race - Ame	
2-003p	be filed within 72 hours after death with the Marylan da Hygiane. I al Hygiane. I other than "natural", or items 23a or 28e-f show other than "natural" or items 23a or 28e-f show event, it a Madical Exacilment must be retilied at	by	1 Never Mårried 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:		if Yes, specify Cuba 1 ☐ Yes X ☐ No	n, Mexican, Puerto R Specify:	ican, etc.)	Black, White	e, etc. WHITE
N-C Z	within 72 ha ene. than "natu i'e Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give life. i	DO NOT use retired	during most of working	9	6b. Kind of Business. SMITHSONI	N.A.
D	filed v Hygie other t	e Co	17. Father's Name (First, Middle, Last)	4	_FINANG	CIAL OFFI	CE MGT DIF 18. Mother's Name		INSTITUTI laiden Sumame)	ON
/Ian		To B	CLIFFORD C. SHREV	'E			MILDE	RED F. I	ARISON	
, Mar)	127 ja d		19a. Informant's Name/Relationship (Type DOROTHY M. SHREVE/				and Number or Rural TILGHMAN			Zip Code)
9	Pages 1 al tment of Hes tant: If item fury or othe		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ Re		lace of Dispo emetery, crer	sition (Name of matory or other plac	Da	ite 2	Oc. Location - City or	Town, State
Baltimor			*4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License			PARK CEM		-2005	BALTIMORE	, MD
n n	Department of the control on the con		JOHN R.	MERCER	TE.	FILOWS H	FIFFNRFIN	& NEWNA	M FUNERAL	HOME PA
	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death	n. Do not ent		g, such as cardiac or			Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying						10	
,00,	te be executed ysician and e burial-transit	cai Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):		CERTIFIE TO MAPPE	OND BY ME CH	EXAMINER	
Q	tificate ig phy: as the					•	CERTIFICATION			
O. Box	at the death certificate by the attending physical ached for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 22 1 No 9 ☐ Unknown	ac. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
ords, F		by	Part II. Other significant conditions con A-F,5 (ou marn Ufc	-	alting in the u	nderlying cause givi	en in Part I.		acco use contribute to	o the cause of death?
ř	sician: The law requires that certificate has sen signed b irector, page 2 should be deta	ompieted	Coumorn Osc					24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
Vital	sician: certifica irector, p	BeC	25. Was case referred to medical examiner?			0.1	26. Place of Death			
ō	ng Phy ter this neral d	tlon: To	1 Nes 2 No 27. Manner of D ath 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Minpatient 2 1 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injury Work	at 28		nce 6 □Other (Spe w injury occurred	cify)
DIVISION	al or Attendir s after death. Il Director: Al	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	reet, factory, office	28	Bf. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical (ician: To the best of my kno er: On the basis of examinal and manner stated.						
	To th Withir To th comp	Me	29b. Signature and title of certifier	110		29c. License			d. Date signed (Mont	h, Day, Year)
•			1///	- MD			·435M1628	8	1/20/02	
			30. Name and address of person who col	mpleted cause of death (Item JARO MA	1 23a) (Type,	Site of Mus	Jaws			
	Sta Registi		31. Date filed (Month, Day, Year)	32. Reginar's Signa	ture	both	· · · · · · · · · · · · · · · · · · ·			

		For Stete Registrar		S	tate o	f Mary	and / Dep <i>Ce</i>	artmeı <i>rtifica</i>				lental H	ygie Reg.	- 61	05	0356
		Decedent's Name	e (First, Midd	le, Last)								2. Date of D		NO.		3. Time of Death
Physici		OSVALDO	imu) c	N) SP	INEI	O.T.O						JANUA		Day 23 2	Year	11:45 a M
/Medio Examir		4a. Facility Name (I		<u> </u>				4b. City	, Town, o	r Location	of Death	DANUA	KI	4c. County	005 of Deeth	11.4J a
CAUTIII	٠.	National	Insti	itutes	of	Healt	h	R	ethes	sda				Mor	tgom	0 * 77
Funeral		5. Social Security N		6. Sex			yrs. last birthday	If Unde	r 1 Year	If Unde	r 24 Hrs.	8. Date of B	irth		9. Birthp	lace (State or Foreign
Director		None		1 🖾 M	2□ F	68	Yrs.	Months	Days	Hours	Min.	(Month, E	14.	1936	Coun	ury)
2		Usual Residence of														
ms 23a or 28a-f show	_	10a. State	10b. County			100	: City, Town or L	ocation							11	Od. Inside City Limits
1 9	5	Italy		lmont			Turin									1XQXYes 2 □ No
or 2	Dire	10e. Street and Nur						10f. Z	ip Code				10g.	Citizen of W	Vhat Coun	itry?
238	<u>e</u>	Via Tetti	Valtr	e 6 -	100	43 Or			None					Italy		
"natural", or Items 23a or 28e-f show idical Examinar must be notified at	Funeral Director	11. Marital Status			Was Dece Armed Fo	edent Ever erces?	in U.S. 13.	Was Dece If Yes, spe	edent of H	lispanic O an, Mexica	rigin? (Spean, Puerto	cify Yes or N Rican, etc.)	lo-		- America k, White, e	an Indian, etc.
P E	by F	1 Never Marri			1 ∐Yes If Yes, Giv	/0		1 🗆 Yes	2 X No	Specify	<i>r</i> :			Specify		
"natural", edical Exp	d b	3 Widowed			Year or D	ates:									lta	lian
	Completed	(Spec	15. Deceder cify only highe	nt's Educations of grade co	on m <i>pleted)</i>		16a. Deci	kind of w	ork done	ation during mo	st of worki	ng	166	. Kind of Bu	siness/Ind	Justry
other then '	g	Elementary/Seco	ndary (0-12)		College (1	1-4or 5+)			230 1011100	,						
ther nt, n		12th 17. Father's Name	(First Middle	Last)			uni	nown		18 Moth	ner's Name	(First, Middl	o Mair	unkno		
940	Be												o, man	Jon Jonnan	0)	
is marked or	ဠ	Attilio 19a. Informani's Na	_		Print)		10h Mai	ing Addros	r /Stmat		nna N	l Route Num	has Ci	h. a.s. Taura	Ctata 7ia	Codel
7 is 7		Liliana G										3 Orba		-		
of Health and Menial Hyglene. I item 27 is marked other then r other treumatic event, the Market.		20a. Method of Disc		-/ WITE	•	20	b. Place of Disp			TIE 0		ate		Location -		, Italy
0 = 10 0		1 Burial 2	Cremation		oval from	State	cemetery, cre	matory or	other plac						•	
rtent pury		` 4 □Donation				G	odino Fu				1-27-			rino,	Ita	ly
Department of Importent: If i eny injury or one		21. Signature of Fu	Ineral Service	Va	is	hal	el !	larsh 217	all's	Fun Tun	eral	Home, Washi	Inc ingt	on, D	.c. 2	20011
		23a. Party. Enter the shock, or hea	he disease, o rt failure. List	r complicati t only one c	ons that c ause on e	aused the	death. Do not er	ter the mo	de of dyin	ig, such a	s cardiac o	r respiratory	arrest,			Approximate Interval Between
/sician		Immediate Cause disease or condition			Ha	VV	Cell	10	stee	wi a						Onset and Death
Medical		resulting in death)			Due to ((or as a cor	nsequence of):									
aminer		Sequentially list co	nditions.	b												
Ħ	ner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nmediate orlying	,	Due to ((or as a cor	nsequence of):									
and I-trans	Examiner	that initiated events resulting in death) I	5	c	Due to ((05.00.0.00.00										
ician and burial-transil	E E	, , , , , , , , , , , , , , , , , , , ,			Due to ((OI as a cor	nsequence of):									
the	dlcal			d												
attending p I for use as	/Me	IF FEMALE:		23c.	If ves. out	come of pr	egnancy							224 Date		
atten for u	by Physician/M	23b. Was deceden in the past 12	months?		1 Live b		Fetal death 3	⊒Ectopic p ⊒ Other (s		,				Mor	e of deliver oth	Day Year
the	ysle	1 □ Yes 2 [9 □ Unknown			9□ Unkno		0. 000	_ Ott 101 (3	pacity)							
ed by detac	F	Part II. Other signif	ficant conditi	ons contrib	uting to de	eath but no	t resulting in the	ınderlying	cause giv	en in Part	l.	23e. Did	tobacc	co use contr	ibute to the	e cause of death?
g a												1 🗆] Yes	2 No	3 🗌 Proba	ably 4 □Unknown
been si should	Completed											04. 145		7		
2 5	Id II					-						24a. Wa auto	s an opsy formed	_ P	vere autop rior to con leath?	psy findings available npletion of cause of
icate ha												1□ Yes	2			212No
certificat rector, pa	Be	25. Was case refer examiner?		Hosp	ital:				0#5		e of Death	(Check only	one)			
this aldi	1 ₀	1 ☐ Yes 2 27. Manner of Deat	*		- 2		2 ER/Outpatie			4 🗆 14		ne 5 Res				"
After	o	1. Natural	5 Pendi	ng	8a. Date (Mont	or injury th, Day Yea	ar) 28b. Time Injury		28c. Injun Worl	k?		28d. Describe	how ir	njury occurre	ed	
	Certification;	2 Accident 3 Suicide	6 Could	not be	On Dines	-6.1-1	A) h = = = - (М		Yes 2		204 1	(0)			
Direction by	it.	4 🗌 Homicide	detern	nined 2	buildi	ing, etc. (S	At home, farm, s pecify)	reet, factor	ry, office		2	City or To			er or Hural	l Route Number,
ours a		29a. Certifier	Certifyi	na Physicia	n. To the	hest of my	knowledge, dea	th occurred	t at the tie	no data a	nd place o	and due to the	2 001100	2(a) and ma		atad
within 24 hours after deal To the Funerel Director: completely tilled in by the	Medical	(Check only one)	2 Medical	Examiner:	On the ba	asis of examer stated.	mination and/or i	vestigation	n, in my o	pinion, de	ath occurre	and due to the	, date	and place, a	nd due to	the cause(s)
within compl	Ž	29b. Signature and	title of certific	/	//		^		c. Licens				29d.	Date signed	(Month, D	Day, Year)
(n)			1/1	1 9	a		-M	> 1	136-	-///	053	3	1	123	109	5
10		30. Name and addr	ess of person	who comp	leted caus					, ,					-	
Syl		Mic	hael	2.	C	itto.	can C	ENTE	את א	TVE	ਸਵਾਧ	HESDA	\ 1	MD 20	1892	
Sta	te	31. Date filed (Mon		1	32. R	legistrar's S							-7	···	, U J Z	
Regist	ar	JAN 25	2005	Place	4	W 1	marke)									

			1 - For State Registrar	State of Mary		artment of rtificate of		R	eg. No. 2005	03569
ı	Physici /Medio	al	1. Decedent's Name (First, Middle, Las Louise B. Sutton			r		2. Date of Dea Month January	Day Year 23, 2005	3. Time of Death 2:30 a M
	Examir	er	4a. Facility Name (If not institution, give Washington Advent		1	4b. City, Town, Takoma	or Location of D Park	eath	4c. County of Death Montgomer	
	Funeral Director		5. Social Security Number 6. S 246-48-0274 Usual Residence of Decedent	OM WELL	yrs. last birthday) 2 Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Birth (Month, Day)		place (State or Foreign ntry) h Carolina
	e Maryland ie-f ehow	ctor	10a. State 10b. County MD Prince (c. City, Town or Lo					10d. Inside City Limits 1 ⊈Yes 2 ☐ No
	with th	Director	10e. Street and Number 2127 Keating St.			10f. Zip Code		1	0g. Citizen of What Cou	ntry?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28e-f show other treumatic event, the Medical Examinatmust he notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2₹☐ No If Yes, Give Year or Dates:		20748 Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 ③ No	Hispanic Origina ban, Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)	USA 14. Race - Ameri Black, White, Specify: Blac	etc.
21215-0036	in 72 ho "natura edical i	Completed	15. Decedent's Ec (Specify only highest gra	de completed)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	upation a during most of ed)	working	16b. Kind of Business/In	
212	giene. giene. er thar	Som	Elementary/Secondary (0-12)	College (1-4or 5+)		ase Work			Government	
Maryland	should be file and Mental Hy s marked oth umatic event	To Be	17. Father's Name (First, Middle, Last) John A. Baldwin				Paulir	Name (First, Middle, I ne Dudley		
Mar	and 2 sho ealth and n 27 Is m		19a. Informant's Name/Relationship (1 Evelyn Shaw	Гуре, Print)				r Rural Route Number nple Hills	City or Town, State, Zip. MD 20748	Code)
altimore,	iges 1 au nt of Hea If Item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State		matory or other pla			20c. Location - City or To	
Baltin	permit. Pages 1 and Depertment of Heali Importent: If Item 2 any Injury or other once.		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen			2. Name and Addr	ess of Facility J	Johnson &	Hallsboro, I Jenkins Fund ton, DC 2001	eral Home
8760,	The law requires that the death certificate be executed Example 1	dical Examiner	23a. Part1. Enter the disease, or comy shock, or heart failure. List only the shock of the shock	Due to (or as a co	nsequence of):	ic p			Fibrosis	Approximate interval Between Onset and Death
O. Box 6	that the death certificated by the attending placed for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date of delive Month	ery Day Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	nderlying cause g	iven in Part I.		pacco use contribute to the	· /
al Records,		Completed						24a. Was a autops perform 1 🗆 Yes 2	y prior to co	psy findings available mpletion of cause of
Division of Vital	alng Phy I. After this funeral c	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Man er of Denth 1 atural 5 Pending investigation	Hospital: 1 npatient 28a. D. te of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of Injury	28c. Inju	ther: 4 Nursin		a) once 6 □Other (Specifi ow injury occurred	(v)
Divis	tel or Attences after death	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S		eet, factory, office		28f. Location (St. City or Town	reet and Number or Rura n, State)	l Route Number,
	To the Hospite Whin 24 hours To the Funerel	edical (29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of mainer: On the basis of exa and manner stated.	y knowledge, death mination and/or in	n occurred at the t vestigation, in my	ime, date and pla opinion, death o	ace, and due to the ca courred at the time, da	ause(s) and manner as s ate and place, and due to	ated. o the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	2),1			se number	+7-1	ed. Date signed (Month,	Day, Year)
	Age		30. Name and address of erson who of	Negvs	518	Print)	vashi	ngton	Adven	154 Hogo
	Sta Registi		31. Date filed (Month Jay, Year) JAN 2 5 2005	32. Registrar's	And I					7

		Tor State Registrar 1. Decedent's Name (First, Middle, Las			-	rtificate of	lealth and M Death		1. No. 200	5 03570	
sicia edic		Eloise Smith			Mont			Month	nth Day Yeer		
min	er	4a. Fecility Name (If not institution, give street and number)					r Location of Death		4c. County of Death		
		Southern Maryland		Clinton,		n , If Under 24 Hrs.		Prince George			
ral tor		5. Sociel Security Number 6. Security Number 226-30-5103	7. Age (In yrs. last birthday) M 2 F 78 Yrs.			If Under 1 Year Months Days	Hours Min.	May 17,	9. Birthplace (State or Country) 17,1926 Lynchburg, V.		
	ł	10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits	
	ţō	Maryland Prince George Forres				111e			1 ☐ Yes 2 ☐ No		
Trott	lrec	10e. Street and Number				10f. Zip Code	g. Citizen of What (Country?			
	0	7217 Beltz Drive							nited Sta	ites	
any injury or other traumatic event, the Mudical Examinar count be multified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced 12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			er in U.S. 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue) 1 Yes 2 No Specify:			ecify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, nite, etc. Black	
	Completed	15. Decedent's Ed	ucation		16a. Deced	dent's Usual Occup	ation	16	Bb. Kind of Busines	s/Industry	
1	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)				KING OF WORK GONE O DO NOT use retired	during most of work 1)	ang			
	5	Twelve	Three		Chef			F	rivate		
	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nan		e (First, Middle, Ma	iden Sumame)	Sumame)	
atic	၉	John Cobbins					Ruth Ha				
1		19a. Informant's Name/Relationship (7)					and Number or Run				
l	1	Hilda V. Pendletor	1/Daughter				rive, For				
		20a. Method of Disposition 1☆ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,		cen	netery, cren	sition (Name of matory or other plac emorial		ry 27,	oc. Location - City of		
ć		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert G. Mas							ason Fune	ral Home	
		Dagal. day	L MO,	1111	16	61 Good !	Hope Rd E	E, Washin	igton DC	20020	
		resulting in death)			Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death	
l	dical Examiner										
	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1						23d. Date of delivery Month Day Year		
	ρχ	Part II. Other significant conditions contributing to death but not resulting in the un				nderlying cause give	en in Part I.	cco use contribute to the cause of death? 2			
oage 2 sho	Completed							24a. Was an autopsy performe	prior to		
	Be (25. Was case referred to medical					26. Place of Death	h (Check only one)			
	ToE	examiner? 1 Yes 2 No	Hospital: 1 Inpatie	nt 2 EF	R/Outpatien	t 3 DOA Othe		me 5 Residence		ecify)	
		27. Manner of Death 1 Alatural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Tir				Work		28d. Describe how			
	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specily)			ie, farm, stri	treet, factory, office 28f. Location (Stree City or Town, S			et and Number or Rurel Route Number, State)		
led in by the funeral director, page 2 should be d	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Madical Exam	rsician: To the best of inar: On the basis of and manner sta	examination	ledge, death on and/or inv	n occurred at the tim vestigation, in my op	ne, date and place, pinion, death occurr	and due to the caused at the time, date	to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)		
	Σ	29b. Signature and title of certified 29c. License number 29c.					d. Date signed (Month, Day, Year)				
		Nahme mi)					DO055120 Jan enue SE Surt 310 WASHINGTONS			nuany 21 2005	
	L									(-003	

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2242 PM Barbara 05 Jean Smith JAnuar /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince chever14 6-eures 1005 vince Ľ. ta If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 07/18/1950 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□M 2□F 54 Virginia 579-68-2194 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a, State 10b. County Items 23a or 28a-f show the Medical Examiner hast be notified at 1 √Yes 2 No Director Prince Georges' Lanham 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 2915 Hobble Bush Court 20706 death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black δ 3 ☐ Widowed 4 Divorced 'naturel' Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Decupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Coltege (1-4or 5+) Elementary/Secondary (0-12) Legal Secretary permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: if Item 27 is marked other the any injury or other traumatic event, the once. years Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ernest L. Freeman Gloria A. Bowers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Tonya A. Simmons - Daughter 725 Cattail Circle; Raleigh, N. Carolina 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 01/28/2005 | Brentwood, Maryland 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service Licensee andamitreena P.O. Box 416; Suitland, Maryland 20752 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List doly one cause on each line. Immediate Cause (Finat disease or condition resulting in death) erotic Cardiovascular Heart Disea Atherosch **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. s been signe should be d þ 3 Probably 4 Nhknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No 2 No certificate of Vital To the Hospital or Attending Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2.☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred After Division Injury 1 Natural 5 Pending after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tntury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 22 Madicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number HO055927 90 30. Name and address of person who person cause of death (tem 23a) (Type, Print) Hospital Drive Chewerly, MARY land SALVA don 31. Date filed (Month) 32. Registrar's S State Registrar

		For State Registrar 1. Decedent's Name (First, Middle, Las	State of Marylan		artment of F rtificate of			Reg. No.	2000	0357	
Physicia /Medica	al -	JANICE M.	SMITH				Month Januar	y 19	2005	3. Time of Death 5:40 P	
Examine uneral irector		212-68-2395	e # C-3	# C-3 7. Age (In yrs. last birthday)		4b. City, Town, or Location of Death Forestville If Under 1 Year If Under 24 Hrs. Months Days Hours Min.			4c. County of Death Prince George's Prince George's 9. Birthplace (State or Foreign Maryland)		
Ba-f show	Director	Usual Residence of Decedent		y, Town or Lo	stville					10d. Inside City Limi 1 ⊠ Yes 2 ☐ N	
23a or 2	al Dire	7310 Donnell Plac						zen of What Co $S.A.$	ountry?		
o, le	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Dovorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 232 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		(Specify Yes or No uerto Rican, etc.)	-	14. Race - Ame Black, Whit Specify:		
han "natura e Medical E	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)		dent's Usual Occup kind of work done DO NOT use retire			Kind of Business/Industry			
₽ €	o Be Cor	12th 17. Father's Name (First, Middle, Last) Charles Edwary Ta	ylor Sr.	raphic Sp	st Name <i>(First, Middl</i> e, Ley Silln	Maiden					
7 is	F	19a. Informant's Name/Relationship (7		3108	May Gree	en Avenu	Rural Route Numbe				
Important: If itam 2 any injury or othar once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify)) R	esurre	sition (Name of matory or other pla	me. 1/2		Cli	nton, Ma	ryland	
any ir		21. Signature of Euneral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785									
	ical Examiner	shock, or heart failure. List only of disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cares distort of any leading to immediate cares (Disease or injury that initiated events resulting in death) Last	areoid	esis				Interval Between Onset and Death			
attending p for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of di 9 Unknown	th 2 Fetal death 3 Ectopic pregnancy nt at time of death 5 Other (specify)						23d. Date of delivery Month Day Year	
be d	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacc							co use contribute to the cause of death?		
has 9e 2	Completed						24a. Was autop perfo 1 🗆 Yes		24b. Were au prior to death?	topsy findings available ompletion of cause	
rect	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ★ Residence 6 ☐ Other (Specify)								
neral	ertification; T	27. Manner of Death Matural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M			28c. Injury at Work? 28d. Describe how					
neral Director: Af	O	3 Suicide 6 Could not be determined	building, etc. (Specify)				City or Tov	8f. Location (Street and Number or Rural Route Number, City or Town, State)			
completely illed	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the caus of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.						date and	e and place, and due to the cause(s)		
200	~	29b. Signature and title of certifier Aus Ste	inberg M						d. Date signed (Month, Day, Year)		
6/	L	30. Name and address of person who o									

			, FOI	partment of Health and Mertificate of Death	lental Hygie	•	0357
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last) Mildred Strahl 4a. Facility Name (If not institution, give street and number) National Lutheran Home	4b. City, Town, or Location of Death Rockville	2. Date of Death Month Jan . 23 ,	Day Year 2005 4c. County of Death Montgom	3. Time of Death $10:05A^{M}$ ery
	Funeral Director		5. Social Security Number 234-92-3956 6. Sex 1 M 2 1 F 92 Yrs	Months Days Hours Min.	8. Date of Birth (Month, Day,) Jan . 4 , 1	(ear) 9. Birthol (count (913 Ohi	ace (State or Foreign try) O
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Md. Montgomery 10c. City, Town or	Rockville		10	Od. Inside City Limits 1 XYes 2 □ No
	h with the	al Direc	10e. Street and Number 9701 - Veirs Drive	10f. Zip Code 20850	100	g. Citizen of What Coun USA	try?
920	be filed within 72 hours atter death with the Maryland ital Hygiene. d other than "natural" or Itams 23a or 28a-f show evant, I're Medical Exerting to ust be rigitlish at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto □ Yes 2 □ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, & Specify: Whi	etc.
215-0	ithin 72 ho ie. ien "natur i.M.cical	npieted	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work e. DO NOT use retired)	ing 16	6b. Kind of Business/Ind	ustry
Maryland 21215-0036	be filed tal Hygi ed other	To Be Cor	12 17. Father's Name (First, Middle, Last) John McCoy		ie Ann	<u>At Home</u> aiden Sumame) Roseberry	
Mary	d 2 shi th and th sm 17 lsm traum	F	19a. Informant's Name/Relationship (Type, Print) Charles A. Strahl- Son 139	ailing Address (Street and Number or Run 205- Wisteria Dr	ive, Ge	City or Town, State, Zip rmantown,	Code) Md.20874
Baltimore,	Pages 1 an nent of Heal int: If itam 2 iry or othar		20a. Method of Disposition 1 🛱 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify)	sposition (Name of crematory or other place) Seenwood Cem. 1/28		Dc. Location - City or Too Bellaire,	
Balti	permit. Pages Department of I Important: If its any injury or of		21. Signature of Funerat Service Licensee	22. Name and Address of Facility Hysong Co., In	nc.	IIl. DO	
760,	ate be executed yield and was in and will and in the burial-transit he burial-transit and was a second of the burial-transit and was a	Ical Examiner	23a. Part1. Enter the disease, of complications that caused the death. Do not shock, or heart failure. List only one cause in the chine. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Cospiratory Cli	stress	Synelm	Interval Batween Onset and Deat
.O. Box 68	at the death certificat by the attending phy tached for use as th	Physician/Med		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliver Month	y Day Year
۵.	requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		cco use contribute to the	
Vital Records,	sician: The law re s certificate has ber lirector, page 2 sho	Completed	V		24a. Was an autopsy penforme 1 Yes 2	prior to corr	sy findings available pletion of cause of 2 No
Division of Vita	To the Hospital or Attanding Physician: The law requires that the death certifica within 24 hours after death. To the Funaral Diractor: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as it	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 NAV 27. Manner of Peath 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be	tient 3 DOA Other: 4 Harring Ho e of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how		
Divi	oital or At urs after o iral Diraci		4 Homicide determined 286. Place of Injury - At nome, farm, building, etc. (Specify)		City or Town,		
	o tha Hosp within 24 ho o tha Funa completely fi	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/o and manner stated. 29b. Signature/and title of certifier	path occurred at the time, date and place, r investigation, in my opinion, death occurred. 29c. License number	ed at the time, date	se(s) and manner as sta a and place, and due to I. Date signed (Month, E	the cause(s)
	(6)		30. Name and address of person who completed cause of death (Item 23a) (Tyr	W21726 De, Print)	l/e	energy	3,2005
	Sta	ite	Dr. Charles W. Karesh- 9701- 31. Date filed (Month, Day, Year) 32. Registrar's Signature		ille,Md	20850	
	Registi		JAN 2 5 2005 Bleen & John				

			1 - For State Registrar		Marylan	-	artmen tificate			and M		g. No	005	035	74
	Physici	an	1. Decedent's Name (First, Middle, La Anita Frances								2. Date of Death Month	Day	Year	3. Time of	
	/Medic		4a. Facility Name (If not institution, give		er)		4h City	Town or	Location of	f Death	January	22,	2005 ounty of Death	4:15	A M
	Examin	er	Anne Arundel Med						polis				ne Arur		
	Funeral Director			Sex 7 1 □ M 2 □ F	Age (In yrs. 97	last birthday) Yrs.			If Under:		8. Date of Birth (Month, Day, 12/21/			place (State o	r Foreign
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside Ci	ity Limits
	Maryli f sho	5	Maryland Anne Ar	undel		Annapo								1 TYes	
	7.28e	Director	10e. Street and Number			шаро	10f. Zip	Code			10	g. Citîze	n of What Cou	ntry?	
	th with	ai D	2700 South Haven	Road			2	1401				Ţ	JSA		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "naturel", or Items 23a or 28e-f show any injury or other traumatic event, I're Medical Examinar must be indiffied at ODGe.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? ⊒ 4 No		Was Deced f Yes, spec 1 Yes 2	rfy Cubar	n, Mexican	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)		Race - Ameri Black, White pecify: Wh		
215-0	hin 72 ho e. an "natur Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		or 5+)	16a. Deced (Give life.	dent's Usua kind of wor DO NOT us	il Occupa rk done d se retired,	ition Juring mosi)	of workin	ng 1	6b. Kind	of Business/Ir	ndustry	
2	ed wit ygien yarthi t. Ire	Con	12		,	H	ome M	aker					vn Home	-	
Maryland 21215-0036	ould be fill Mental H arkad ott atic even	То Ве	17. Father's Name (First, Middle, Lass Thomas (Di) Be	nedetto					I	illi	(First, Middle, M.	1			
Jar	l 2 sho and r Is m		19a. Informant's Name/Relationship								l Route Number,	2015101		p Code)	
Baltimore, 1	ges 1 and of Health If Item 27 or other t		Patrick Flynn - 20a. Method of Disposition 1 Burial 2 □ Cremation 3 1		te c	Place of Dispo semetery, crer	sition (Nan natory or o	ne of ther place	a)	Ď		0c. Loca	tion - City or T		
ţ	t. Pag tment tant: ijury o		`4 Donation 5 ☐ Other (Speci	fy)	For			-			6/2005	Brer	twood,	MD	
Bal	permii Depar Impor any Ir once.		21. Signature of Funeral Service Lice Myelin T. Keller	#		22	Name an			•	Fort I Rd; Bre	inco	ln Fun	eral H 20722	ome
	Physician /Medical Examiner	-	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Uri Due to (or	ı line.	Iract I			g, such as	cardiac o	r respiratory arre	st,		Approximate Interval Bett Onset and I	ween
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequ										
P.O. Box 68	it the death certifica by the attending ph tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ②CNo 9 ☐ Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	2 Fetal	Ideath 3□	Ectopic pr Other (sp					230	I. Date of deliv Month	-	/ear
	es tha	þ	Part II. Other significant conditions Chronic Obstru					ause give	en in Part I.				contribute to t		
Records,	The law requir ate has been si page 2 should	Completed	Hypertension								24a. Was an autopsy perform	ed?	death?	mpletion of ca	available ause of
ital		0	Dementia 25. Was case referred to medical						26. Place	of Death	(Check only one	No No	1 🗌 Yes	2□ No	
Į <	ys Si Gii	To B	examiner? 1 ☐ Yes 2 【XNo	Hospital: 1 X Inpa	atient 2	ER/Outpatier	t 3 DC	Othe			ne 5 Resider		Other (Special	fy)	
Division of Vital	ding h. Aftei fune		27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of I (Month, i	njury Da <i>y</i> Yea <i>r)</i>	28b. Time of Injury	M 2	8c. Injury Work	at ? /es 2 ☐ I		28d. Describe how	v injury o	ccurred		
Divis	D it o	Certification:	3 Suicide 6 Could not to determine determined	286. Place of	Injury - At ho etc. (Specify	ome, farm, str y)	eet, factory	, office		2	28f. Location (Str. City or Town,		lumber or Run	al Route Num.	ber,
	Yo the Hospitel or Attention 24 hours after deatl To the Funerel Director: completely filled in by the	edicai C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the be miner: On the basis and manner	s of examina	wledge, death tion and/or in	occurred vestigation,	at the tim in my op	e, date an	d place, a	ind due to the ca ed at the time, da	use(s) an te and pla	d manner as s ace, and due t	stated. o the cause(s)
	To the	Me	29b. Signature and title of certifier	1/2			290	License			29	d. Date s	igned (Month,	Day, Year)	
1	11.		Man	de				D45	5925			Janu	ary 22,	, 2005	
(Ugge		30. Name and address of person who Dr. C. Ufomadli	completed cause of Anne		n 23a) (Type, el Medi		Cente	er	Annar	colis, M	aryla	and 21	401	
	Sta Registi		JAN 2 5 2005	32. Regi	strar's Signa	ature						_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** $\underline{A}^{\mathsf{M}}$ Radford Schantz 20, January 2005 8:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7008 Barkwater Court Montgomery Bethesda if Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 09/26/1925 If Under 1 Year Months Days 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 79 Director 074-18-4230 Georgía Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28a-f ahow the Medical Exercities must be notified at 1 X Yes 2 ☐ No Directo MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 20817 U.S.A. Funeral 7008 Barkwater Court death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural; or item any injury or othar traumatic event, the Medical Eventuarians. 1 Never Married 2 Married If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 🕅 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Economist Consulting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Radford Bonds Sarah Chambers 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7008 Barkwater Court, Bethesda, Maryland 20817 Erika Schantz, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 01/24/2005 Brentwood, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Fun val Servic Linensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 6 weeks Metastatic Lung Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician Physician/Medical the attending IF FEMALE ase 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 4☐Pregnant at time of death the 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 certificate 2**X** No 1 Yes To tha Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 0 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 1 XNatural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide hours after within 24 hours a' 29a. Certifier 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0033293 January 20, 2005

Registrar

State

DHMH 17 Rev 1/200

w

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

5454 Wisconsin Ave. Ste. 1300, Chevy Chase, MD 20815

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick Smith, MD, 31. Date filed (Month, Day, Year)

JAN 2 1 2005

Physiciai /Medica Examine

Funeral Director

perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-1 show any injury or other treumetic event, the Madical Examination and the page.

Physician /Medical **Examiner**

Baltimore, Maryland 21215-0036

Sn	nith Please T	ype or Prin	t in Black I	ndelible lnk.	Ensure Al	II Copies	Are I	_egible.	
	1 - For State Registrar	State of Ma	_	partment of H ertificate of I			giene Reg. No.	20,05	03577
	1. Decedent's Name (First, Middle, Last)					2. Date of De. _ Month	Day	Year	3. Time of Death
i		ITH, III				Januar		, 2005°	11:55 A M
	4a. Facility Name (If not institution, give s Anne Arundel Medic				Location of Death		4c.	County of Deat	
	5. Social Security Number 6. Sex		(In yrs. last birthda	Annapo	If Under 24 Hrs.	8. Date of Birt	th	Anne A	
	,		29 Yrs.	Months Days	Hours Min.	Month, Da Nov. 23,	y, Year) 197	5 Wash	hplace (State or Foreign untry) nington, D.C.
	Usual Residence of Decedent							wasi	irington, D.C.
	10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
	Maryland Frederick		Freder	Lck					1X Yes 2 □ No
	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	untry?
3	8941 Walter Martz			21702				S.A.	
2	77. Wallar States	12. Was Decedent E Armed Forces?	1995	Was Decedent of Harmonian StreetIf Yes, specify Cuba	spanic Origin? (Spi n, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 1	 Race - Ame Black, White 	
5	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	to 1997	1□Yes 2⊠No	Specify:			Specify: Wh	ite
מנכת בא	15. Decedent's Educ	cation	16a, De	cedent's Usual Occupa	ation		16b. Kir	d of Business/	Industry
2	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5	(Gi	ve kind of work done o DO NOT use retired	furing most of work)	ing	Deli	very	
	12th			mercial Dr	iver		Serv	ices	
2	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden :	Surname)	
2	John Joseph Smi	ith, Jr.			Juni I				
	19a. Informant's Name/Relationship (Ty)			tiling Address (Street a					
	John Joseph Smith,	, Jr./Fath		Walter Ma		, Fredei			
	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	emoval from State	cemetery, c	rematory or other plac	θ)			cation - City or	
ij	'4 □ Donation 5 □ Other (Specify)		Fort Lir	coln Crema		26/2005	Brei	itwood,	Maryland
	21. Signature of Funeral Service License		į. i	22. Name and Addres	DI FUNER	AL HOME	IN	C	VD 2000/
	23a. Part 1. Enter the disease, or compli	cations that caused						r Sprin	g, MD 20904 Approximate
	23a. Part1. Enter the disease, or complishock, or beart failure. List only or Immediate Cause (Final	e cause on each lin	0.)						Interval Between Onset and Death
	disease or condition resulting in death)	Heac	a consequence on:	will					
		Due to (or as a	consequence ou.	J					
5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequence of):						
	Cause (Disease or injury that initiated events								
	resulting in death) Last	Due to (or as a	a consequence of):						
3		J							
	IF FEMALE:								
	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth	2 Fetal death	3 □Ectopic pregnancy			2	3d. Date of deli Month	very Day Year
2	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death	5 Other (specify)					-uy .ou.
	Part II. Other significant conditions con	ntributing to death bu	ut not resulting in the	underlying cause give	en in Part I.	23e, Did to	obacco us	e contribute to	the cause of death?
2	•	•	,				res 2		obably 4 Unknown
						24a. Was		Odb Wasa av	tone, findings available
na dina						autop		prior to death?	topsy findings available completion of cause of
	25. Was case referred to medical				00 Pl :-	1 Yes	2 🗆 No	1 Yes	2□ No
	examiner?	lospital: 1	nt 2 XER/Outpat	iont 30 DOA Othe	26. Place of Death			Other (C-	sife)
	27. Manner of Death	28a. Date of Injur	y 28b. Time	of 28c. Injury	at	me 5 L Hesio 28d. Describe I			, ,
	1 □ Natural 5 □ Pending investigation	(Month Day		SAM X	(? /es 2 □ No	Decoas	Acres	tr c	head
1	Suicide 6 ☐ Could not be determined	28e. Place of Inju	irv - At home farm	street, factory, office		28f. cation (S	Street and	Number or Ru	ral Route Number.
5	- LITOMORG	Dullding, etc	FFice 6	milding	(Edge	otte	7.W.T	mo ka
200	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examir	sician: To the best of ner: On the basis of and manner sta	examination and/or	eath occurred at the time investigation, in my op	e, date and place, pinion, death occurr	and due to the red at the time,	cause(s) a	and manner as place, and due	stated. to the cause(s)
	29b. Signature and the of pentier	A A		29c. License	number		29d. Date	signed (Month	n, Day, Year)
	MAD 11	11/11	1		CME			2011	

within 24 hours after ceath.

To the Funeral Direc*or: After this c*rtificate has been signed by the attending physician and completely filled in by he funeral director, page 2 should be detached for use as the burial-transit

To the Hospitel or Atlanding Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

10

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

JAN 2 1 2005

3 Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

			For State Registrar	State of Ma	-		tment of H <i>ficate of L</i>		, ,	iene _{eg. No.} 200	5 03578
	Physici		Decedent's Name (First, Middle, Last ROSALIND	,	HWARTZBA	СН			2. Date of Dear Month JANUARY	Day Year	3. Time of Death 3:12 A M
	/Medic Examin		4a. Facility Name (If not institution, give SUBURBAN HOSPITA)	e street and number)			b. City, Town, or	Location of Death	J	4c. County of De.	ath
	Funeral Director		5. Social Security Number 6. S	ex 7. Ag	e (In yrs. last birtl 93 Y		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day JUNE 12	9. B , 1911 NI	rthplace (State or Foreign country) LW YORK
	the Maryland	Director	Usual Residence of Decedent 10a. State 10b. County MARYLAND MONTGOM 10e. Street and Number	ERY	10c. City, Town		tion 10f. Zip Code		1	0g. Citizen of What (10d. Inside City Limits 1 Yes 2 No
920	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show dreal Exam or must be rodified at	by Funerai	5225 POOKS HILL RO 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	DAD, #717 12. Was Decedent Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	Ever in U.S.	If Y	20814 is Decedent of Hi res, specify Cubar Yes 2X No	spanic Origin? (S _I n, Mexican, Puerti Specify:	pecify Yes or No- p Rican, etc.)	UNITED ST	erican Indian,
21215-0036	f within jiene. r than "	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5 2	5+)	(Give kii life. DC	nt's Usual Occupa nd of work done of NOT use retired, KEEPER	luring most of wor.	king	16b. Kind of Busines GARMENT	s/Industry
Maryland	should be filed nd Mental Hygi s marked other umatic event, it	To Be (17. Father's Name (First, Middle, Last) BARNETT	SCHWARTZB				ESTHE		STERN	
Baltimore, Mar	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked eny injury or other treumatic events.		19a. Informant's Name/Relationship (SUSAN E. SCHWARTZ) 20a. Method of Disposition 1	BACH, NIE	CE 522 20b. Place of cemetery	25 Positive of Positive Communication (Property of Positive Commun	OOKS HIL ion (Name of tory or other place EK CEMETI Name and Addres ZANSKY-G	L ROAD, ERY JAN s of Facility OLDBERG	#1828 SO Date 25, 2005 MEMORIAL	CHAPELS,	SDA, MD 20814 r Town, State ARRE, PA
	Fnysician /Medical Examiner	iner	23a. Part1. Enter the disease, or com sock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	one cause on each ling aCONGEST Due to (or as bSEVERE	I the death. Do note. IVE HEAR a consequence of MITRAL For a consequence of a consequence of a consequence of the consequence	ot enter RT FA f): REGU	the mode of dying	g, such as cardiac		ILLE, MD	Approximate Interval Between Onset and Death 4 MONTHS
). Box 68760,	e death certificate be executed he attending physician and ed for use as the burial-transit	Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No	d. 23c. If yes, outcome	2 Fetal death	3 □E	ctopic pregnancy Other (specify)			23d. Date of d	olivery Day Year
Vital Records, P.O.	law requires that the de as been signed by the a 2 should be detached	Completed by Phy	9 □ Unknown Part II. Other significant conditions of HYPERTEN	ontributing to death b	ut not resulting in	the und	erlying cause give	on in Part I.	1 ☐ Ye	n 24b. Were a	to the cause of death? Probably 4 Unknown ultopsy findings available completion of cause of
of	ding Phy: ician: The I h. After this certificate ha funeral director, page	To Be	25. Was case referred to medical examiner? 1 X Yes 2 No 27. Manner of Death 1 X Natural 5 Pending investigation investigation.	Hospital: 1 Inpatie	ry 28b. T		3 DOA Othe	er: 4 🗆 Nursing H	th (Check only on	2. No 1 □ Ye	s 2□No
Division	or Attender fer deat lirector:	Certification;	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		ury - At home, far c. (Specify)	m, stree			28f. Location (St City or Town	reet and Number or F n, State)	Bural Route Number,
	To the Hospitel of within 24 hours at To the Funeral D completely filled it	Medical ((Check only 2 Medical Exar	ysician: To the best niner: On the basis of and manner sta	f examination and		stigation, in my op	inion, death occu	rred at the time, d	ate and place, and du	e to the cause(s)
) ,	2 F 2 5	~	29b. Signature and title of Certifier	ul _				0535		9d. Date signed (Mor	
	Sta Registi		30. Name and across of person who ROGER STEVENSON, 31. Date filed (Month, Day, Year)	JR., M.D.,		OCKL	EDGE DRI	VE, #200	BETHESD	A, MARYLAN	ID 20817

0312 1/20/05

Accalin Schuartzbeit

DHMH 17 Rev 1/2001

Registrar

2 4 2005

			For State Registrar	State of Marylar	nd / Depa	artment of rtificate of	Health ar f <i>Death</i>	nd Mental H	ygiene Reg. No.		03580
			1. Decedent's Name (First, Middle, Las	t)				2. Date of D	eath Day	Year	3. Time of Death
	Physici /Medic		Geraldine	A. Smith				Janua		2005	8:35 A M
	Examin		4a. Facility Name (If not institution, give				or Location of	Death		County of Dea	
			Montgomery Gen			01 ne				Mo nt gor	
	Funeral		5. Social Security Number 6. Social Security Number 1	The olde	last birthday) Yrs.	If Under 1 Yea Months Day		Min. 8. Date of B (Month, D Sept.	irth Day, Year) 1710	0	thplace (State or Foreign ountry)
	Director		233 56 4541	69				s ept.	17 19	35 W e	st Virginia
	yland 10w		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits
	Mar.	tor	Md. Montgo	mery S	Silver	Spring					1 ☐ Yes 2 🖔 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What C	ountry?
	23e ust b		14045 Breeze H	ill Lane			20906			nited S	tates
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin ban, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)	lo-	 Race - Am Black, Whi 	
36	s afte		1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1□ Yes 2XN	o Specify:			Specify:	White
Ş	filed within 72 hours after death with the Maryland Hygiene ther then "natural", or Items 23e or 28e-f show ant, I've Medical Evarther must be reciffed at	Completed by	15. Decedent's Ed		16a, Dece	dent's Usual Occi	upation		16b. Ki	nd of Business	/Industry
15	n "na	plet	(Specify only highest gra	de completed)	(Give	kind of work don DO NOT use retir	e during most o red)	of working			
212	d with giene ar the	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Admi	nistrato	or		Sc	ience	Res earch
D D	0 = 0 ≥	Be (17. Father's Name (First, Middle, Last)				18. Mother's	s Name (First, Middl			
yla	2 should be filled within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then "natural", or liems 23e or 28e-f show to marked other then "natural", or liems 23e or 28e-f show the unatic event. It's Medical Examinating mast be redified at	2	Notley Russe				Ann			Swiger	
Maryland 21215-0036	2 sh and is m reum		19a. Informant's Name/Relationship (7 Halsey W. Smith,	*		-		or Rural Route Num. Lane, Silv	-		
	1 and Health em 27 ther to		20a. Method of Disposition		_			Date Date	-	pring,	
و	Pages ment of b ent: If it		1 ☐ Burial 2 🗷 Cremation 3 🗆			nsition (Name of matory or other pi				010	
altimore,	artme artent ortent injury		4 □ Donation 5 □ Other (Specify21. Signature of Funeral Service Licen			itan Cr		1/23/05		exandr	
Ba	permit. Pages 1 and 2 should b Department of Health and Menta Importent: If item 27 is marked any injury or other treumetic e one.		muriel &	V. Barbe		Muriel	1. Barb 30x 5038	er Funera B, Laytons	l Hom Svill	e. Md.	20882
			23a. Part1. Enter the disease or comp shock, or heart failure. List only	olications that caused the dea	th. Do not ent	er the mode of dy	ing, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between
3	Physician :		Immediate Cause (Final disease or condition	MYOCARDI	AL INF	ARCT TON					Onset and Death
	/Medical		resulting in death)	Due to (or as a consec		711107 2011					
	Examiner		Sequentially list conditions,	b. —							
	ed sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):						
	and and Il-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):						
8760,	death certificate be executed e attending physician and od for use as the burial-transit	dical E		d							
89	ificate g phy as the	edic									
Вох	leath certific attending p	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		Bectopic pregnan	CV.		2	23d. Date of de	livery
	deat ne att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of c		Other (specify)		·		Month	Day Year
P.O.	res that the de igned by the a be detached t	by Physician/Me	9 Unknown		S					-	
Vital Records,	w requires that the been signed by the should be detache	ed by I	Part II. Other significant conditions of SEVERE COPD	ontributing to death but not res	sulting in the u	nderlying cause g	given in Part I.		tobacco u Yes 2[o the cause of death?
000	> 11 (A)	Completed	HYPERTENSION					24a. Wa	s an	24b. Were a	utopsy findings available completion of cause of
ř	The law	Com	TYPE II DM					peri 1 Yes	ormed?	death?	2 No
/ita	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place o	Death (Check only	one)		
7	hys this	ဥ	1 Yes 2 No		ER/Outpatier	IL SU DON		ing Home 5 Res			ecify)
U C	ding F h. After funera	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	W		28d. Døscribe	how infun	cocurred	
S	Attender death ector: by the f	cat	2 Accident investigation 3 Suicide 6 Could not be		ome farm et		Yes 2 No		(Street and	d Number or B	ural Route Number,
Division of	5 5 5 6	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy)	eet, ractory, onice	9		wn, State		urar rioute riumber,
	To the Hospitel o within 24 hours at To the Funerel D completely filled in	edical C	29a. Certifier (Check only one)	ysician: To the best of my kno liner: On the basis of examina	owledge, death ation and/or in	h occurred at the vestigation, in my	time, date and opinion, death	place, and due to the occurred at the time	cause(s) , date and	and manner a place, and du	s stated. e to the cause(s)
	o the	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licer	nse number		29d. Date	e signed (Mon	th, Day, Year)
			Muchant	Offer Mi)		M	05041	0	JAN	UARY 21	1, 2005
	10			completed cause of death (Iter		Print)					
	i i		MICHAEL KERR, M				PHILIP	DRIVE, O	LNEY,	MD. 2	20832
	Sta Registr	_	31. Date filed (Month, Day, Year) JAN 2 4 2	32. Pigistrar's Signature	B A	partie					

			For State Registrar	State	of Maryla		artment of rtificate of	Health and I Death	Mental Hy	giene A	2005	0358
h	Physici	an	1. Decedent's Name (First, Middle,		Calbarre	:-1-			2. Date of De Month	Day	Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution,	lice V.		ете	4b. City, Town,	or Location of Deat	Januar h	_	2005 unty of Deeth	6:05 P ^M
Ž		-	11926 Frederick		7.4. (1.		Ellico	ott City	0.0000000000000000000000000000000000000		loward	10.
	Funeral Director		5. Social Security Number 220 24 0884	3. Sex 1 ☐ M 2 🛂 F	7. Age (In yn	s. last birthday) Yrs.	Months Day:			th 1 <i>y, Year)</i> 2 , 1921	9. Birthi Coul	place (State or Foreign ntry) Tyland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. (City, Town or Lo	cation					10d. Inside City Limits
	Maryl	tor	MD Howard	1	El	licott	Citv					1 ☐ Yes 2 No
	or 286	Direc	10e. Street and Number				10f. Zip Code			_	of What Coul	•
	eath w	Funeral Director	11926 Frederick		edent Ever in	U.S. 13.1)42 Hispanic Origin? (S	Specify Yes or No		ted Sta	
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Items 23a or 28e-f ehow marked other than "natural", or litems 23a or 28e-f ehow maric event, the Madigal Esamither main by notified at	by	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed F	orces? 2 ⊠ No ive	'	fYes, specify Cu 1 ☐ Yes 222 No	ban, Mexican, Puer	to Rican, etc.)	'	Black, White, ecity:	
21215-0036	72 hou	Completed	15. Decedent's (Specify only highest	Education grade completed,)	(Give	dent's Usual Occi	during most of wo	rking	16b. Kind o	of Business/In	
1212	filed within 72 Hygiene. other then "nai	ldmo	Elementary/Secondary (0-12)	College	(1-4or 5+)		nsed Pra	ed) actical Nu	ırse	Hospi	tal	
	al Hyg al Hyg d other	BeC	17. Father's Name (First, Middle, L	•				18. Mother's Nar	me (First, Middle			
Maryland	should be nd Mental marked o	ည	Joseph N. Selby 19a. Informant's Name/Relationsh			10h Mailir	a Address /Stra	Viola Ea		or City or To	um Stato Ziu	2 Code)
	alth ar 11th ar 27 io		William F. Scheu		./Son			oard Rd S				
ore,	Pages 1 ar		20a. Method of Disposition 1 Burial 2 Cremation		20b.	. Place of Dispo cemetery, crer	sition (Name of matory or other pi	ace)	Date	20c. Location	on - City or To	own, State
altimore,			* 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L	ecify)	C			Gard. 1-2				
Ba	permit. Departr Imports any inji		> Stem Col	lus-la	the	4	112 Old	Columbia	Pike El	licott		ly FH Inc. MD 21043
7	Physician		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediete Cause (Final disease or condition resulting in death)	omplications that nly one cause on a.	each line.			ing, such as cardia			J.	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	equence of):						
	P =	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Oue to	(or dis a consi	ednauca ot).						
	xecute and al-trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a cons	equence of):						
8760	cate be executed physician and s the burial-transit	dlcal E		d							-	
9		/Med	IF FEMALE:	23c. If yes, or	itcome of preg	nancv				224	Date of delive	00/
O. Box	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♣ No 9 ☐ Unknown	1 ☐Live	birth 2∏Fe nant at time of	etal death 3	Ectopic pregnan Other (specify)	cy		250.	Month	Day Year
Vital Records, P.	quires that n signed b uld be deta		Part II. Other significant condition	S contributing to	_	esulting in the u		iven in Part I.		obacco use d Yes 2 No		he cause of death?
eco	e law require has been si ye 2 should b	Completed	LHYPERTEN						24a. Was	psv	prior to co	psy findings available mpletion of cause of
a E				TEO AR	THILL	Ŗ			1 ☐ Yes	rmed? 2.XNo	death?	No No
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ysicier is certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No	Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3 DOA	thon	ath <i>(Check only i</i> Home 5⊠ Resi		Other (Specia	(v)
ion of	ing Ph After th uneral		27. Manner of Death 1			28b. Time of	28c. Inj		28d. Describe			,,
Division	el or Attend s after death N Director: ed in by the	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 200. Flat	e of Injury - At ling, etc. (Spe	home, farm, str	eet, factory, office		28f. Location (City or To	Street and Nu wn, State)	ımber or Rum	al Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: , completely filled in by the f	edical (29a. Certifier 1 X Certifying (Check only one) 1 Medical E	xaminer: On the	e best of my k basis of exami nner stated.	nowledge, death nation and/or in	n occurred at the vestigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and date and place	manner as s ce, and due to	tated. o the cause(s)
,	To t withi To tl	M	29b. Signature and talle of certified	Ma	wo	NO	29c. Lice	299 bg			gned (Month,	
9			30. Name and address of person w	97 5	VITE		Print)	ov MD	2173	,		
	Sta Registr		31. Date filed (Month, Day, Year) JAN 25	2005	Pegistrar's Sig	nature #	boats 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year KOBE 20:078 MULLIKY 200 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner ptia 5. Social Security Number 7. Age (Inffrs. last birthday) **Funeral** Days Hours 15€M 2□ F Yrs. Director 67 126-28-9579 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits worls Examiner must be notified at VA Loudoun 1 ☐ Yes 2 ☑ No Director Sterling 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 20392 Brightwater Place 20165 **USA** Itams 23a Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Heatth and Mental Hygiene. Int: If item 27 Ia marked othar than "natural", or Itams 23 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No
If Yes, Give
Year or Dates: 1960 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No White þ 3 ☐ Widowed 4 ☐ Divorced Completed treumatic evant, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Analyst C.I.A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ward Willard Swain Margaret Mary Lennon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Josephine Swain - Wife 20392 Brightwater Place Sterling, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If its any injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Chestnut Grove Cem. 102/01/2005 Herndon, VA 22. Name and Address of Facility 21. Signature of Funeral Service L 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician System a. Multi disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to as a consequence of) 68760 Be Completed by Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliver 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. icate has been sig r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 (XNO 1 Yes 2 No To tha Hospital or Attanding Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide on 24 hours.

tha Funaral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical npletely (Check only one) and manner stated within 2 29b. Signature and title of certiff 29c. License number KES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/200

State

Registrar

Erics, Weiss, MP 31. Date filed (Month, Day,

Yea

2005

PODOXIOTOWER, 600 NORTHWOIFE STREET, BALTIMORE, MARYLAND

EN I	TUNG		1- For Unpend Item 23a,27,28a-f per me C340 2-11-05 tas Certificate of Death	Mental Hy	giene 005 03583
	Physici /Medio	cal	1. Decedent's Name (First, Middle, Last) Yen G. Tung 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	2. Date of De. Month JAN.	ath 20, 2005 3. Time of Death 5:25 P M
7	Examir	ier	SHADY GROVE ADVENTIST HOSPITAL S. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min	8. Date of Birt	4c. Country of Death MONTGOMERY th y, Year) 9. Birthplace (State or Foreign Country)
	Director works		212-31-8822	09/19/	1922 China 10d. Inside City Limits
	th the Mary or 28a-f sh	irector	MD Montgomery Rockville 10e. Street and Number 10f. Zip Code		1 ☐ Yes 2 No 10g. Citizen of What Country?
99	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show may joury or pether traumatic event, it is Madical Examiliar metal buncilliad at annone.	by Funeral Director	12321 Briarbush Lane 11. Marital Status 1 Never Married 2 Married 2 Married 1 2 Married 2 Married 2 Married 2 Married 1 2 Married 2 Married 1 2 Married 2 Married 1 2 Married 2	Specify Yes or Norto Rican, etc.)	
Maryland 21215-0036	ithin 72 hours ie. ian "natural", i.Medical Ex.	Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	orking	Specify: Asian 16b. Kind of Business/Industry
land 21	uld be filed wi dental Hygien rkad othar th lic event, the	To Be Con	6 Construction Worker 17. Father's Name (First, Middle, Last) 18. Mother's Na unk	me (First, Middle,	Construction Maiden Surmame)
	1 and 2 shou Health and M am 27 is mai ther traumal		19a. Informant's Name/Relationship (Type, Print) Vincent Tung, Son 19b. Mailing Address (Street and Number or R 12321 Briarbush Lane,		le, Maryland 20854
Baltimore,	mit. Pages bartment of h cortant: If its injury or el	ň	1 □ Burial 2 X Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Ft. Lincoln Crematory 02/0		
m i	Ped IIII			ke, Rocky	ville, Maryland 20852
3760,	Physician /Medical Examiner physician and physician and physician and physician and ithe physician and physician a	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dilltiazem Intoxication Complicating Due to (or as a consequence of):	Metasta	tic Lung Carcinoma
P.O. Box 68	w requires that the death certific. been signed by the attending pl should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
rds, P	v requires that been signed b should be deta	þ	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to the cause of death? Yes 2 🕅 No 3 🗆 Probably 4 🗇 Unknown
tal Reco	ysician: The law r is certificate has be director, page 2 sh	e Completed	25. Was case referred to medical 26. Place of De		sy prior to completion of cause of death? 2 \(\text{No} \) 1 \(\text{X} \) Yes 2 \(\text{No} \) No
Division of Vital Records,	Phys this at di	To B	examiner? 2 No Hospital: X Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing 4 N	28d. Describe h	lence 6 Other (Specify) tow injury occurred Ingested Pills
Divis	oital or Attaurs after desertal Directo	Certification;	Suicide 4 Homicide Suicide 4 Homicide Suicide	Potomac	
	To the Hospital or Atlanding Phenical Atlanta Safer death. To the Funaral Director: Atlant completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 29b. Signature and title of certifier 29c. License number O.C.M.E	urred at the time, o	date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) JAN. 27, 2005
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7	E,MARYLA	ND 21201

		For State O State O Registrar 1. Decedent's Name (First, Middle, Last)			2. Date of Dea	
Physicia /Medica		FRANCES LOUISE SHORT THO	OMPSON		JANUAR	Day Year
Examine		a. Facility Name (If not institution, give street and nu	mber)	4b. City, Town, or Location		4c. County of Death
		CIVISTA MEDICAL CENT 5. Social Security Number 6. Sex		LA PLATA	24 Hrs. a = 4 Pi	CHARLES
Funeral Director		217–30–0535	7. Age (In yrs. last birthday) 85 Yrs.	Months Days Hours	24 Hrs. 8. Date of Birth Min. (Month, Day AUGUST 3	9. Birthplace (State or Fore
with the Maryland a or 28a-f ahow	.	10a. State 10b. County MARYLAND CHARLES	10c. City, Town or Lo BRYANS RO			10d. Inside City Lim 1 ☐ Yes 2
th with the 23a or 28 unt be no	<u> </u>	10e. Street and Number 6880 ROCK SPRING PLACE /	P.O. BOX 334	10f. Zip Code 20616	1	Og. Citizen of What Country? UNITED STATES
033 .	by Fur	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Dec Armed Fo F	2 🔼 No ve 1	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicar 1 ☐ Yes 2 🌠 No Specify:	gin? (Specify Yes or No- i, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
<u> 후</u> 등 등 행 1	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (:	life. I	dent's Usual Occupation kind of work done during mos DO NOT use retired)	t of working	16b. Kind of Business/Industry
1212.	5	UNKNOWN	NURS	SING ASSISTANT		HEALTH CARE
be fill Hall Hall Hall Hall Hall Hall Hall H	e	17. Father's Name (First, Middle, Last) JAMES L. SHORT		ELSI	er's Name (First, Middle, I E MAE MINOR	SHORT
Ma nd 2 st lith ar 127 la r r trau		19a. Informant's Name/Relationship (Type, Print) FRANCES M. THOMPSON / DAUGHTER				; City or Town, State, Zip Code) 3 BRYANS ROAD, MARYLAND 2
Tore to the or oth	:	20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ Removal from		natory or other place)		20c. Location - City or Town, State
Baltimore, Baltimore, permit. Pages 1 a Department of Hee Important: If itam any injury or otha		*4 □Donation 5 □Other (Specify) 21. Strature of Fundry 7 ervice Sense December 1	27	Name and Address of Eacilit	ĎME PA	GLYMONT, MARYLAND
m g0= a a	-	23a Part 1. Enter the disease or complications that of	MU0583 34	439 LIVINGSTON RO	AD, INDIAN HEA	
Physician /Medical Examiner				y failure		Interval Between Onset and Death
760, i be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events c.	(or as a consequence of):	www.	<u>Ubacea</u>	y vien along
76(te be ysicia	28	d	or as a consequence of).	CERTIFIC	ANON APPROVED BY MEDI	CAL EXAMINER
, P.O. Box 68:		in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	Ē,	Part II. Other significant conditions contributing to de	eath but not resulting in the un	nderlying cause given in Part I.		accoluse contribute to the cause of death?
ords, P	הׄ מ				1 ☐ Ye	/
Records,	Completed by				24a. Was ar autops	v prior to completion of cause of
	be completed by	25. Was case referred to medical examiner? 1 N Yes Hospital:	Protient 0 5000 and in	04	24a. Was at autops perform 1 Yes 2	prior to completion of cause of death? No 1 Yes 2 No
on of Vital on of Vital ling Physician: After this certifica	to be completed by	examiner? 1 X Yes Hospital: 1 1	npatient 2 □ ER/Outpatient of Injury 28b. Time of Injury Injury	04	24a. Was ar autops perform 1 Yes 2 of Death (Check only one rsing Home 5 Reside 28d. Describe ho	prior to completion of cause of death? If No 1 Yes 2 No DOI: 10 No 1 No DOI: 10 Yes 2 No DOI: 10 Ye
on of Vital on of Vital ling Physician: After this certifica	to be completed by	examiner? 1 Yes 27. Manner of Death 1 Triatural 2 Accident 3 Suicide examiner? 1 Hospital: 1 28a. Date of Mont (Mont) 28a. Sacretary 28a. Place 46termined 28a. Place 28a. Place 28a. Place		28c. Injury at Work? M 1 Yes 2 1	24a. Was an autops perform 1 Yes 2 of Death (Check only one rsing Home 5 Reside 28d. Describe ho	prior to completion of cause of death? No 1 Yes 2 No No 1 Yes 2 No Other (Specify) w injury occurred
on of Vital on of Vital ling Physician: After this certifica	edical Certification; 10 be Completed by	examiner? 1 Yes 27. Manner of Death 28. Date (Mont) 29. Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 29a. Monting investigation 6 Could not be determined 28a. Place building 28b. Place building 29a. Certifier (Check only) 29 Medical Examiner: On the base of the part of the	of Injury th, Day Year) 28b. Time of Injury of Injury - At home, farm, stre ng, etc. (Specify)	t 3 DOA Other: 4 Nu. 28c. Injury at Work? M 1 Yes 2 No. pet, factory, office	24a. Was an autops perform 1 Yes 2 of Death (Check only one rsing Home 5 Reside 28d. Describe how 28f. Location (Str. City or Town	prior to completion of cause of death? No 1 Yes 2 No No 1 Yes 2 No Other (Specify) w injury occurred reet and Number or Rural Route Number, State)
Division of Vital Bivision of Vital The Hospital or Attending Physician: In 24 hours after death. The Funaral Director: After this certifice pletely filled in by the funeral director.	legical certification; 10 be completed by	examiner? 1 Yes 27. Manner of Death 28. Date (Mont) 29. Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 29a. Monting investigation 6 Could not be determined 28a. Place building 28b. Place building 29a. Certifier (Check only) 29 Medical Examiner: On the base of the part of the	of Injury th, Day Year) 28b. Time of Injury of Injury - At home, farm, stre ng, etc. (Specify) best of my knowledge, death asis of examination and/or inv	t 3 DOA Other: 4 Nu. 28c. Injury at Work? M 1 Yes 2 No. pet, factory, office	24a. Was a autops perform 1 2 4 2 3 3 4 5 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	prior to completion of cause of death? Prior to completion of cause of death? Prior to completion of cause of death. Prior to completion of cause of deat

State of Maryland / Department of Health and Mental Hygiene [] [] 5

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Jan. 21, 2005 **Physician** L1ewel1yn Henry Taylor 3:35a. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Prince Georges Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jul 21, 1927 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1√2 M 2□ F 77 Yrs Wash. D.C. 230-20-9224 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State "natural", or Itams 23a or 28a-f show odical Examiner must be notified at 1 ☐ Yes 2 No Prince Georges Clinton Direct 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 9700 Foxcroft Ave. 20735 U.S.A. Funeral 12. Was Decedent Ever in U.S. Amed Forces? 12☐Yes 2☐No If Yes, Give Year or Dates: 1952-55 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, ite Medical Examinations. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Completed by Black 3 Widowed 4 XDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Custodian School System 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Porter H. Taylor Elizabeth Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sandy Taylor(Daughter) 3731 Huntly Meadows Lane, Alexandria, Va. 22306 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2-1-05 * 4 ☐ Donation 5 ☐ Other (Specify) Ouantico National Cem; Quantico, Va. 22. Name and Address of Facility
Lewis Funeral Home
311 N.Patrick St., Alexandria, Va. 21. Signatu 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. Listonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Examiner The law requires that the death certificate be executed the attending physicien and hed for use as the burial-tran Due to (or as a consequence of) O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 2 should be 12 3 robably 4 | Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 1 ☐ Yes 2 ☐ No 2 No certificate 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA Ē Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: completely filled in by the 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AB346HA SAN 31. Date filed Month, 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 ar **Physician** 9:05 AMM JAN. 17 WILSON A. TAYLOR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** QUEEN ANNE'S CORSICA HILLS ASSISTED LIVING CENTREVILLE If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Dey, Yeer) JULY 24,1922 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1 X M 2 ☐ F MARYLAND Yrs. 213-24-4769 Director 82 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f ahow the Medical Examiner treat be notified at 1 XYes 2 No SUDLERSVILLE QUEEN ANNE'S Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with ö 21668 USA 139 W. MAIN STREET or itema 23a Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: 1939–1944 Specify: WHITE Be Completed by 3 Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) TRUCKING TRUCK DRIVER , 9 -0permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If Item 27 is marked other
any injury or other traumast 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SUZY B. ROLLISON WENDELL H. TAYLOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 CHESLOU AVENUE, CHESTER, MD 21619 19a. Informant's Name/Relationship (Type, Print) WILSON A. TAYLOR, JR./ SON Baltimore, 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State MARYLAND VETERAN CEMETERY 1-21-2005 HURLOCK, MD * 4 □ Donation 5 □ Other (Specify) 21. Signatur y ral Service Licen As FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or como shock, or heert failure. List only or cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Munu home Obi Ctractus **Physician** 54: /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: Alter this certificate has been signed by the attending physician and completely tilled in by the Innertal firector, page 2 should be detached for use as the burial transit Due to (or as a consequence of): Box 68760. by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier 29c. License number 31836 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Clarke, Md 2/6/9 Co 2108 Donah 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 0 200 F Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 U U 5 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month Year **Physician** 9:10 Am ANDREW VRABLIC TAN 9 2005 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner **FUTURE CARE CHESAPEAKE** ARNOLD ANNE ARUNDEL if Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Days 1**☆** M 2□ F Months Hours Yrs. Director 216-12-6911 81 MD Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene. other than "natural", or items 23a or 28a-i show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shorthe Madical Examiner roust be notified at 1 ☐ Yes 2 X No Director QUEEN ANNE'S **STEVENSVILLE** 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 503 BROADCREEK DRIVE 21666 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 XYes 2 □ No 1943-If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Maritel Status 1 Never Merried 2 Merried 3altimore, Maryland 21215-0020 1 ☐ Yes 2 👿 No Specify: Specify: WHITE Š 3 Widowed 4 Divorced Year or Dates: 1945 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry ring most of working Elementary/Secondary (0-12) College (1-4or 5+) 6 CHARTER BOAT CAPTAIN MARINE permit. Pagas 1 and 2 should be file Departmant of Health and Mental Hy Important: If Itam 27 Is marked oth any Injury or other traumatic event 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOSEPH VRABLIC HELEN OSUSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) PAUL VRABLIC/SON 503 BROADCREEK DRIVE, STEVENSVILLE, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date MARYLAND VETERANS CEMETERY JAN. 25 2005 1
☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) HURLOCK, MD 21. Signature of Euneral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical e. 1schemic Cardianyope. Ch.

Due to (or as a consequence of): Examiner Physician/Medical Examiner CORONARY ARTERY for use as the burial-transit Attending Physician: The law raquires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, that initieted events resulting in deeth) Lest Due to (or as a consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown ital or Attenums.

Wis after death.

eral Director: After this certificate has been wighter the funeral director, page 2 should be detailed to the funeral director, page 2 should be deather. REFRACTORY ASCITES ģ Completed 24a. Was en autopsy performed? Were eutopsy findings available prior to RENAL FAILURE completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes cese referred to medical examiner? 26. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Mennes of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Naturel 5 Pending investigation 1 Yes 2 No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C completaly filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) none 30. Neme end address of person who completed ceuse of deeth (Item 23e) (Type, Print) 3601 Veterans UCS millessille

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day, Year)

32. Register's Signeture

2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 24, 2005° 5:44 A M **Physician** Vogelsang William Α. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Ft. Washington Ft. Washington Hospital 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1/1/9/12/19/19 9. Birthplace (State or Foreign Country) Texas 5. Social Security Number 7. Age (In yrs. last birthday) 85 yrs. **Funeral** Days Hours x 🖾 🛨 2 □ F 452-24-7624 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X X No Temple Hills Prince George's Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20748 USA 5202 Oahu Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinations. Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specity: þ XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) <u>United States Marine Corps</u> Military 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Susie Marugg Oscar E. Vogelsang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3490 Elsa Avenue Waldorf, Maryland Michael W. Vogelsan a / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1/26/05 Edgewater, Maryland 5 ☐ Other (Specify) Kalas Crematory 4 Donation. 22. Name and Address GEOTTE P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20745 alus) 23a. Part. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction **Physician** /Medical Due to (or as a consequence of): **Examiner** Chronic Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ng physician and as the burial-transit Due to (or as a consequence of): ed by the attending physician detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No XXX robably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 🙀 No 1 Yes 2 No al or Attending Physician: after death. funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 XX After this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 1 X Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D41182 1/24/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 9400 Livingston Road #250 Ft. Washington, MD 20744 Felton Anderson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death I. Decedent's Name (First, Middle, Last) Month **Physician** P M 19, 2005 7:40 Jessie Verbin January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Collingswood Nursing Center If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 X F Months Days Hours 95 November 7, 1909 Pennsylvania Director 211-52-9347 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Cepartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any july or other traumatic avant, the Medical Evantriant be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No Director Rockville MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 299 Hurley Avenue Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specity: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Dress Shop/ Clothing Dressmaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Esther Smull Maurice Goldsmith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11309 Spur Wheel Lane, Potomac, Maryland 20854 Arthur Verbin, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 01/21/2005 Olney, Maryland 4 □ Donation 5 □ Other (Specify) Judean Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part. Enter the disease, or complications that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death tmmediate Cause (Final a End Stage Dementia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 X No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Certification; To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed' 1 ☐ Yes 2 X No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 1 Inpatient funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 XNatural 1 Tes 2 No 2 Accident neral Diractor: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 Pertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0057124 1/20/05 - uno 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao, MD, 13219 Executive Park Terrace, Germantown, Maryland 20874 Begistrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 1 2005 Registrar

1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** January Eugene Louis Vermeersch 31 2005 2107 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Union Hospital Ceci1 Llkton ELIKUJI If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 29, 10 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1∰M 2□F Yrs. Director 380-34-2128 68 1936 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Item 27 is marked other than "neturel", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 📉 No Director Maryland Ceci1 Elkton the 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 828 Union Church Road 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: δ 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Annual be filled within 72. Important: If Item 27 is marked other than "netu any injury or other traumatic event and pince. 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Commercial Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Louis Vermeersch Helen May Eierhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Vermeersch/Wife 828 Union Church Road, Elkton, Maryland 21921 20a. Method of Disposition

1 ABurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 4, * 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery Union, Maryland 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** DAYS ENCEPHALOPATHY ANOXIC /Medical Due to (or as a consequence of): **Examiner TEAKS** ALTERY DISEASE CORUNANY Securations list concilions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examine burial-transit YEARS HTPELLIPIDEMIA that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical HYPERTENSION use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Ao 24a Was an autopsy performed 1 Yes 2 No Hospitel or Attending Physicien: 24 hours after death. Funerel Director: After this certifics 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ FR/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel of within 24 hours af To the Funerel D 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number February 1, 2005 D0047711 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 304-306 NORL Street Suite #3 ELLION MAKYLAND 21921 DANIO GAL-EL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State Registrar Decedent's Name (First, Middle, La	st)	Ce	rtificate of	Deam	Reg	J. No.	0 3 5 9
sician		Louis Eldred	•				January	20 2005	
edica ıminer		a. Facility Name (If not institution, given			4b. City, Town,	or Location of Death		4c. County of Dea	
		5401 Bonnie B	Brook Road		Cambr			Dorches	ster
		5. Social Security Number 6. S 217–14–6992 Usual Residence of Decedent	Sex 7. Age (In) ★ 7. Age (In)	yrs. last birthday Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,) July 7,	(ear) 9. Bi 1924 II	rthplace (State or Fore Country) Linois
ļ		10a. State 10b. County 10b Dorche		City, Town or L	ocation Cambr	idge			10d. Inside City Lim 1 ☐ Yes 2 🔀
once. To Re Completed by Funeral Director		10e. Street and Number 5401 Bonnie Br	ook Road		10f. Zip Code	21613	10	g. Citizen of What C	Country?
Completed by Funeral	Dy I dile	1. Marital Status 1. Never Married 2. Married 3. Widowed 4. Divorced	12. Was Decedent Ever in Armed Forces? 1 102 Yes 2 □ No If Yes, Give Year or Dates: W	in U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Wh Specify:	
nieted	Deleg	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Dece (Give life.	edent's Usual Occu e kind of work done DO NOT use retir	pation during most of worl ed)	king	6b. Kind of Busines	s/Industry
0	5	11	5+		veterin	· · · · · · · · · · · · · · · · · · ·		pharmace	eutical
To Be	ב	7. Father's Name (First, Middle, Last Louis B. Van P					ne (First, Middle, Me a Eldredg		
		19a. Informant's Name/Relationship (Thomas Van Pette				at and Number or Ru dge Road,			Zip Code) '850
		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Juenioval nom State		osition (Name of ematory or other plant y Cremat	1 .		oc. Location - City o Salisbury	
		21. Signature of Funeral Service Lice			22. Name and Add	- 1		eral Home	
		23a. Part Enter the disease, or comshock, or heart failure. List only	n~			t St., Car			
ical Examiner	LA LA	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con d.	sequence of): Sten Consequence of):		si lure			interval Between Onset and Death 6 month
Physician/Med	lysician march	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnan	cy		23d. Date of de Month	slivery Day Year
2	2	Part II. Other significant conditions	,	t resulting in the	underlying cause g	iven in Part I.	23e. Did toba		to the cause of death?
Completed	and in or						24a. Was an autopsy performe	ed? death?	utopsy findings availa completion of cause s 2 \(\sum \text{No}\)
Bo	U	25. Was case referred to medical examiner?	80				th (Check only one))	
on. To Be Comple	1	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatie 28b. Time Injury	of 28c. Inju	ury at ork?	ome 5 esiden 28d. Describe how	ce 6 Other (Sp. injury occurred	ecify)
Cartification.	a mican	2 Accident investigation 3 Suicide 6 Could not to determined	De Diana et leium	At home, farm, so]Yes 2□No	28f. Location (Stre City or Town,		Rural Route Number,
Madical		29a. Certifier 1 Certifying P (Check only one) 2 Medicel Exe	hysician: To the best of my miner: On the basis of exar and manner stated.	/ knowledge, dea mination and/or i	ith occurred at the nvestigation, in my	time, date and place, opinion, death occur	, and due to the cau rred at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
Mo	100	29b. Signature and title of certifier	~		29c. Licer	nse number	290	d. Date signed (Mon	nth, Day, Year)
		- gladrion	100			05997	3 1	1/20/05	
		30. Name and address of person who	completed cause of death.	(Item 23a) /Tuna	Print\				

			1 - For Amend Item 2 Registrar	State of Maryland Per Dr., G844	/ Depa • ,06/0	rtmer 6/20 tilicat	t of Health ai 5dhb <i>e of Death</i>	nd Me	ental Hyg	giene Reg. No.	05	03592
V	Physici	an	Decedent's Name (First, Middle, Last) LENORA INGRI	D WALKER					2. Date of Dea Month	Day	Year 2005	3. Time of Death 12:38 P ^M
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City,	Town, or Location of		11110111(1	4c. County	-	12.50 1
	LAGIIII	Ŭ.	PRINCE GEORGE'S HO	SPITAL		CHE	VERLY			PRINC	E GE	ORGE 'S
.,	Funeral Director		217-74-7971	7. Age (In yrs. Ia 1 M 2 1 4 7	st birthday) Yrs.	If Unde Months	r 1 Year If Under 2 Days Hours	Min.	B. Date of Birt (Month, Da pril 1	y, Year)	Cou	place (State or Foreign ntry) HINGTON, DC
	anyland ahow	,	Usual Residence of Decedent 10a. State 10b. County		Town or Lo							10d. Inside City Limits 1 ☑ Yes 2 ☑ No
	Ne W	Director	MD PRINCE GE	CORGE 'S SEA	AT PLE	LASAN 10f. Zij				10g. Citizen of	What Cou	
	with I	ä	()& GLEN WILLOW DE	OTVE # 17		207				U.S.A.	Wilat Cou	iidy :
	death ms 23	Funeral		12. Was Decedent Ever in U.S	i. 13. y	Nas Dece	dent of Hispanic Origi	in? (Spec	ify Yes or No	14. Ra		can Indian,
030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f ahow any injury or other traumatic avent, Ite Madical Enginiter coast be notified at ADG.	þ	1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □ Yes 2 [XNo If Yes, Give Year or Dates:			cify Cuban, Mexican, 2X No Specify:	Puerto H	ican, etc.)	Specil	ck, White	, etc. LACK
<u>2</u>	"natur	eted	15. Decedent's Edu (Specify only highest grade		(Give	kind of wo	al Occupation ork done during most of	of working	7	16b. Kind of B	usiness/Ir	ndustry
21215-0036	within line w	Completed	Elementary/Secondary (0-12)	Coltege (1-4or 5+) 4			se retired)			GOVERN	1ENT	
Maryland 2	d be filed ntal Hyg ed other: avent,	Be	17. Father's Name (First, Middle, Last) LEON WALKER SR.							Maiden Sumai	пө)	
ary	should nd Me mark umarid	To	19a, Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address	s (Street and Number				, State, Zi	p Code) 20747
e, e	1 and 2 Health a em 27 is		Leon Walker Sr/Fa	20b. Pla	1407 ace of Dispo	Shady sition (Na	Glen Driv		istric		ts, M	aryland
Baitimore,	Pages ient of nt: If it ry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	metery, crer mony	-		/22/0)5 1	Landove	r.Mar	vland
aiti	permit. Departm Importa any inju		21. Signature of Funeral Service License				nd Address of Facility			nkins F		
n	20 E 2 9						Landover R				yland	
1	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the death. the cause on each line. Due to (or as a consequi-					respiratory ar	rest,		Approximate Interval Between Onset and Death
35	/Medical Examiner		resulting in death)									
	ned nest	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence)								
8760,	icate be executed physician and s the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequ	ence of):	- Jane						
9	rtificat ng phy as the	Medi	IF FEMALE:									
O. Box	he death certifics the attending pt ched for use as t	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3□	Ectopic p Other (s)					ate of deliv onth	ery Day Year
ds, P.O.	requires that the dien signed by the hould be detached	þ	Part II. Other significant conditions con	ntributing to death but not resu	lting in the u	nderlying (cause given in Part I.			obacco use con	tribute to	the cause of death?
Vital Records,	elaw hasb je2s	Completed									Were autoprior to codeath?	opsy findings available omptetion of cause of
ita	ician: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place	of Death	Check only o			
ot <	S S	To	examiner? 1 Yes 2 No		RyOutpatier			sing Hom	e 5 ☐ Resid	dence 6 🗆 Oti	ner (Speci	fy)
	Attending P. r death. ector: After the by the funera	ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	м	28c. Injury at Work? 1 ☐ Yes 2 ☐ N		3d. Describe l	now injury occur	rred	
Division	P de in ∈	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,		eet, factor	y, office	28	of. Location (S City or Tox		ber or Rur	al Route Number,
	e Hospital 24 hours a e Funeral I etely filled	edicai C	29a. Certifier 1. Certifying Phy (Check only 2 Medical Exami	sician: To the best of my knowner: On the basis of examinati and manner stated.	vledge, deat ion and/or in	h occurred vestigation	at the time, date and n, in my opinion, death	place, ar	nd due to the d at the time,	cause(s) and m date and place,	anner as s and due t	stated. to the cause(s)
	To the within 2	Me	29b. Signature and title of certifier	e		-	c. License number			29d. Date signe		
)	(3)		1 (ayands	am int		E	765000	88		01/13	3/05	
	De		30. Name and address of person who co	ompleted cause of death (Item	23а) (Турө,	Print)	ofter 300	1 hor	ptalc	الأسع وا	rever	y, MO 2078
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JAN 2 5 2005	32. Registrar's Signat	ure							

DHMH 17 Rev 1/2001

W. lley, Ear

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JANUARY 18, 2005 10:21 A^M MARIA WAGNER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | AUG. 31, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 X F Yrs. Director 83 **1**921 HUNGARY UNKNOWN Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show treumstic event. The Medical Examinar must be motified at 1 ☐ Yes 2 🗖 No Director N/A N/A POMAZ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? HUNGARY 22 KOLCSEY ST. 2013 Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after of Hygiene and Hygiene other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify: ð 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill timent of Health and Mental H tent: If Item 27 is marked other Be MARIA GALIK ANTAL BALIZS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4110 MAJESTIC LANE, FAIRFAX, VA ROBERT WAGNER/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY | 01/20/2005 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
ADAMS FUNERAL & CREMATION CARE, 814 BESTGATE RD.,
ANNAPOLIS, MD 21401 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final Cerebrol Vesculor Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 8 Securations list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit Caugestive Due to (or as a consequence of): attending physiclan for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 99 1 Tes 2 No 3 Probably 4 Noknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an ormed? 2LX No 1 TYes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 □ Apatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No this er of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident Injury investigation 1 ☐ Yes 2 ☐ No after death. Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certified MA address of erson who completed cause of death (Item 23a) (Type, Print) erson. MD 32. Registrar's Signature 31. Date filed (Month State A STATE OF THE STATE OF

DHMH 17 Rev 1/2001

Registrar

			1- For Amend Item 8 per fh G841 3-4-05 rb Certificate of Death Registrar Registrar
	Physici		1. Decedent's Name (First, Middle, Last) Ardis Lloyd Word 2. Date of Death Month Day Year January 24, 2005 5:20A M
, la +2	/Medic Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Heartfields Assisted Living at Bowie Bowie Prince George
	Funeral Director		5. Social Security Number 067-24-0642 6. Sex 1 M 2 F 97 Yrs. 7. Age (In yrs. last birthday) Months Days Hours Min. White Days Hours Min. 1 Days Hours Min. Sept. 21,1907 California
	72 hours alter death with the Maryland natural; or itams 23c or 28e-f ahow diest Exacitrer rust be notified at	ctor	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince Gorge's Bowie 1 □ Yes 2 ⋈ No
	eath with the ns 23c or 2	Funeral Director	106. Street and Number 107. Zip Code 109. Citizen of What Country? 109. Citizen of What Country? 109. Citizen of What Country? 110. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
900	ours after d ral', or itan Examilier	by	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No If Yes, Specify: 1 Yes 2 No Specify: Specify: White
21215-0036	within 72 ho ene. than "natur re Madical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+) Housewife 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) At Home
Maryland 2	ges 1 and 2 should be filed within 72 hours after death with the Maryla it of Health and Menlarl Hygiene. If file ma 27 is marked other than "natural", or items 23c or 28e-f ahou if it in marked other than "natural", or item 25c or 28e-f ahou or other traumatic avant, the Modical Executive river to confine a	To Be Co	17. Father's Name (First, Middle, Last) Benjamin Preston Lloyd 18. Mother's Name (First, Middle, Maiden Sumame) Lena Cross
-	. 1 and 2 shoi Health and N Iem 27 ia ma othar trauma		19a. Informant's Name/Relationship (Type, Print) David Word/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10600 Brookes Reserve Road Upper Marlboro, Md.20772
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or othar once.		20a. Method of Disposition 1
Bal	permit. Pa Departmen Important any injury		21. Signature of Funeral Service Dense 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 23a. Part. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate
	mysician /Medical		23a. Part. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cardie on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) Landiac Arrest Due to (or as a consequence of):
18	Examiner	ner	Sequentially list conditions, if any, leading to immediate that the First Filhor from Cause (Disease or injury) Atherosclerosis Due to (or as a consequence of):
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	dlcal Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.
O. Box 6	he death certific the attending p ched for use as	hysiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 Yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unkn
rds, P.O	w requires that the d been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypercholesterolemia, Dementia, Parkinsons and 1 Yes 2 No 3 Probably 4 Unknown
al Records,	The law ate has b page 2 sh	Completed	Osteoporosis 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
on of Vital	ing Physician: Th n. After this certificate funeral director, pag	lon: To Be	25. Was case referred to medical examiner? 1
Division	Attanostration description of the Attanostration of the Attanostra	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 5 Homicide 6 Could not be building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To tha Hospital or within 24 hours afte To tha Funaral Dis completely filled in	Medical (29a. Certifier (Check only one) XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
)	Tot	×	29b. Signature and title of certifier Para Thurbar MrD. 29c. License number 29d. Date signed (Month, Day, Year) January 24, 2005
	Sec.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rene Grace, M.D. 9131 Piscataway Road Clinton, mD. 20735
	Sta Regist		31. Date (iled (Month, Day, Year) 32. Registrar's Signature

			, roi	partment of Health and I ertificate of Death	Mental Hygie	0.0.0
	Physici		Decedent's Name (First, Middle, Last) George Edward Ware		2. Date of Death Month January	3. Time of Obath
	/Medic Examir		4a. Facility Name (If not institution, give street and number) St. Mary's Nursing Center	4b. City, Town, or Location of Death Leonard Town		4c. County of Death St. Mary s
i i	Funeral Director		5. Social Security Number 5. Sex 1. XM 2 F Vrs 1. Sex 1.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Sept. 30	9. Birthplace (State or Foreign Country) 1920 Washington, DC
	Maryland a-f ehow	ctor	Maryland St. Mary's Bushwood			10d. Inside City Limits 1X Yes 2 ☐ No
	h with the	I Director	10e. Street and Number 22727 Wicomico Drive	10f. Zip Code 20618		Citizen of What Country?
36	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or Items 23e or 28e-1 show event, the Medicial Examination instilled at	by Funeral	11. Marital Status 1 □ Never Married 2X Marned 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1944 − 1X Yes 2 □ No 11Yes, Give 1946 18 Yes, Give 1946	3. Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puert 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
Baltimore, Maryland 21215-0036	within 72 hou ane. than "nature be Wedical E	Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ive kind of work done during most of wor a. DO NOT use retired) Machinist	king	c. Kind of Business/Industry Tools Operator
land 2	I Hygi other	To Be Co	17. Father's Name (First, Middle, Last) Alonzo Ware		ne (First, Middle, Mai	den Sumame)
Mary	and 2 showsalth and North			ailing Address (Street and Number or Ru 27 Wicomico Dr., Bu		
more,	permit. Pages 1 and 2 should be Department of Health and Menta Important; if Item 27 is marked any Injury or other traumatic evonce.		20a. Method of Disposition 1	sposition (Name of trematory or other place) 1 Veterans Cem. 1/3	Date 200	eltenham, Maryland
Balti	permit. Departmitmporta		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Mo	Guire Fun	eral Service
	Physician /Medical	111200	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Myocardial Infresulting in death)		or respiratory arrest,	Approximate Interval Between Onset and Death minutes
,0	manual ma	Examiner	Sequentially list conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Coronary Arter Due to (or as a consequence of): Due to (or as a consequence of):	y Disease		years
O. Box 68760,	death certific e attending p od for use as	Physician/Medical		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
rds, P.	w requires that the de been signed by the a should be detached t	by	Part II. Other significant conditions contributing to death but not resulting in the Prostate Cancer	underlying cause given in Part I.		co use contribute to the cause of death? 2 No 3 Probably 4 Nunknown
Vital Records,	The law ate has b page 2 sl	Completed		Mar was	24a. Was an autopsy performed 1 Yes 2X	
Vita	Physician: Th this certificate al director, pag	o Be	25. Was case referred to medical examiner? 1 Yes	-	th (Check only one) ome 5 Residence	e 6 ⊡Other (Specify)
Division of	ding h. After funer	atlon: T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	of 28c. injury at	28d. Describe how i	
Ž Q	i Dir e	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	To the Hospitel within 24 hours a To the Funeral completely filled	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, de (Check only one) 1 Medicel Exeminer: On the basis of examination and/or and manner stated.	iath occurred at the time, date and place, investigation, in my opinion, death occur	, and due to the caus rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
)	1C+1	Σ	29b. Signature and fittle of certifier	D 06419		Date signed (Month, Day, Year)
	[30. Name and address of person who completed cause of death (Item 23a) (1y). James P. Jarboe, M.D. 24035 Th		11ywood. M	4D 20636
100	Sta Registi		31. Date filed (Month, Day, Year) 32/Registrar's Signature	ree Notch Road, Ho		

			1 - For State Registrar	State of Ma		epartme Certifica				Reg. No.	2005	03597	
	Physici	an	1. Decedent's Name (First, Middle, Last		Wilso	_			2. Date of D		200 ^{Year}	3. Time of Death	
1	/Medic	al	Jacqueli 4a. Facility Name (If not institution, give		WIISO		T	Location of De	Jan.			1:40 PM	
	Examin	er	14539 Marlboro					Marlb		40.	P.G.		
	Funeral		Social Security Number 6. S		(In yrs. last birth	day) If Und	ler 1 Year	If Under 24 H	frs. 8. Date of Bi	rth		place (State or Foreign ntry)	
	Director		578-86-6165 Usual Residence of Decedent	□M 280 F 4.4	1 Y	rs. Month	s Days	Hours M	in. (Month, D 12-2	ay, Year) 26–60) Was	sh. DC	
	urylan show	_	10a. State 10b. County		10c. City, Town							10d. Inside City Limits	
	Be-f	ct Ct	MD. P.G.		Uppe	r Mar	lbor	o				1 ∰Yes 2 □ No	
	or 20	Funeral Director	10e. Street and Number			10f. 2	Zip Code			10g. Citiz	en of What Cou	ntry?	
	s 23e	rai	14539 Marlboro				2077				S.A.		
	item item	S.	11. Marital Status 1 ☐ Never Married 2€ Married	12. Was Decedent E Armed Forces?		lf Yes, s	edent of His pecify Cuban	spanic Origin? n, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	0- 1	 Race - America Black, White, 		
<u>გ</u>	urs af	b	3 □ Widowed 4 □ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:		1 🗆 Yes	2₩ No	Specify:		3	Specify: Bla	ck	
2-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "netural", or items 23e or 28e-f show event. I've Medical Everting must be notified at	Completed	15. Decedent's Edu	ucation		Decedent's Us				16b. Kin	d of Business/In	dustry	
2	thin 7	pie	(Specify only highest grad	e completed) College (1-4or 5-		Give kind of v life. DO NOT	vork done di use retired)	uring most of a	working				
7	filed withi Hygiene. other than	Son	12th										
ב	m - 0 =	Be	17. Father's Name (First, Middle, Last)	lame (First, Middle									
<u>Ş</u>	12 should be f n and Mental f is marked of raumatic ever	၉	John Amos						eo Eliza				
Maryland 2121	12 sh h and h and 7 is rr		19a. Informant's Name/Relationship (Ty		1				Rural Route Numb				
e)	1 and Health		Carolyn May/S 20a. Method of Disposition	sister					Date			1. 20743	
altimore,	or Fig.		1 Burial 2 □ Cremation 3 □ F		20b. Place of I cemetery						ation - City or To		
≣	it. Pi	ŀ	* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		Harmon		and Address		21/05	Lan	dover,	Md.	
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic expects.		1/amy/ E	Wille	ind	The 814	Hou:	se of	Willian Street,	N W	ın. Svo	2.	
8760,	Physician physician and physician and physician and physician ithe printing that the physician is the physician and physician and physician and physician and physician are physician and physician and physician are physician and physician an	licai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. UTE Due to (or as a b. Due to (or as a c.	a consequence of	CA 1			ac of fespiratory a	illest,		Approximate Interval Between Onset and Death	
P.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ※ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 24 4 □ Pregnant at 19 □ Unknown	2 Fetel death	3 □Ectopic 5 □ Other (23	23d. Date of delivery Month Day		
	signed by the property of the det	þ	Part II. Other significant conditions con	ntributing to death bu	t not resulting in	the underlying	cause giver	n in Part I.		tobacco us Yes 2 🗓	1	he cause of death?	
ò	w require been sig should t	iete							24a. Was	20	24h Wore sute	and findings available	
al Re	n: The la icate has r, page 2	Completed							- auto	psy ormed?	prior to con death?	psy findings available mpletion of cause of	
\rightarrow	Attanding Physician: r death. sector: After this certifics by the funeral director, I	o Be	25. Was case referred to medical examiner?	Hospital:			Other		Death (Check only				
ö	Phys r this eral d	٦.	1 ☐ Yes 2 🙀 No	1 L Inpatier			JUA	4 🗆 Nursing	Home 5 Res			y)	
0	ding th: Afte fune	i	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injun (Month, Day	Year) Inj	ury M	28c. Injury Work? 1 ☐ Y	?` es 2∐No			00001100		
Division of Vital Records,	To the Hospitel or Attending Physicien: The lea within 24 hours after death. To the Funeral Director: After this certificate has completely illied in by the funeral director, page 2	Certification;	2 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (City or To									I Route Number,	
	To tha Hospital or Att within 24 hours after d To tha Funaral Diract completely filled in by	edical (29a. Certifier (Check only one) 1 Certifying Physical Exami	sician: To the best o ner: On the basis of and manner stat	examination and	death occurre for investigation	d at the time on, in my opi	e, date and pla nion, death oc	ice, and due to the curred at the time,	cause(s) a date and p	and manner as si place, and due to	tated. the cause(s)	
	To th Withir To th	Me	29b. Signature and title of certifier			2	9c. License			29d. Date	signed (Month,	Day, Year)	
	6		· curpulea	Q/			P 10	6619		Jane	cary 2	0,2005	
	3		30. Name and address of person who co	ompleted cause of de	eath (Item 23a) (T	ype, Print)					J	,	
_			Corazon Soar	es, M.D.	8200 I	rofes	sion	al Pl	Landov	er	ма		
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 1 20	Jagriegistia	r's Signature	book	9		-41404	<u></u>	riu ,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month January 20 2005 5:15 Eva Mae Waddell 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Cecil Calvert Manor Nursina Home Rising Sun 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Months Days Hours Min. 1 ☐ M 2 💢 F 93 235-46-0887 Yrs. February 20,1911 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No VA Madison Madison 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 145 Covered Bridge Drive 22727 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Valurius Lillu Lola Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 654 Madison, VA 22727

f Disposition (Name of Date 20c.) Joyce Humphrey<u>/daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State January 24, 2005 Coal City, WV 4 ☐ Donation 5 ☐ Other (Specify) Thompson Cemeteru 21. Signature of unerel Service Lie 22. Name and Address of Facility R.T. foard Funeral Home, P.A. S. Queen Street, Rising Sun, MD Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Parkinsons Immediate Cause (Final disease or condition resulting in death) Disease 4 years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2- No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 26. Place of Death Check on one

Physician /Medical Examiner The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

ဥ

Funeral

Director

orant: If item 27 is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic event, the Medical Exemptor must be rotified at

permit, Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene, Important: If item 27 is marked other than "natural", or Itan any injury or other traumatic.

Baltimore, Maryland 21215-0036

death with the Maryland

Physician/Medical þ Completed Be Certification;

teral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detacl

or Attending Physician:

To the Hospital

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death Natural 5 Pending investigation

28a. Date of Injury (Month, Day Year)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other:

W Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 - Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year) 1/21/05

within 24 hours after death. To the Funeral Director: A

completely

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

6 Could not be determined

Prashant Shukly MD 15 S. Parke Street # 400

Aberdeen

000048050

MD 21001

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Kesteen



		ľ	For State State Registrer	e of Maryland / Depa <i>Cer</i>	irtment of Health a <i>tificate of Death</i>		ene2005	03599
	Physici	an	1. Decedent's Name (First, Middle, Last) Phillip K.	Wilkerso	n	2. Date of Death	-	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give street and	d number)	4b. City, Town, or Location of Prince Free	of Death	4c. County of Deat	1 4 0 2
Fi	uneral	•	Calvert Memorial F 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under		Ca1	holace (State or Foreign
	rector		214-54-1123	F 59 Yrs.	Months Days Hours	24 Hrs. 8. Date of Birth Min. June I	, 1945 Ma	ryland
aryland	show	7	10a. State 10b. County Maryland Calvert	10c. City, Town or Lo	oation Owings			10d. Inside City Limits 1 ☐ Yes 2 🕅 No
th the M	or 28a-f	irecto	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Co	L
leath wil	ns 23e o	Funeral Director	7790 Solomons Isl		20736 Was Decedent of Hispanic Ori	igin? (Specify Yes or No-	USA	nican Indian.
13-UUSO 172 hours after death with the Maryland	Important: If item 27 is marked other than "neturel", or items 23e or 28a-1 show eny injury or other traumatic event, the Medical Examinat must be notified at once.	þ	Arme 1 Never Married 2 Married 1 If Yes	fes 21€1No	Was Decedent of Hispanic Ori Yes, specify Cuban, Mexicar I□Yes 🎢 No Specify:		Black, Whit	e, etc.
2 3-0 hin 72 ho	an "netu Medical	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle	ted) (Give	lent's Usual Occupation kind of work done during mos DO NOT use retired)	st of working	6b. Kind of Business/	
filed wit	ther th	е Соп	5 17. Father's Name (First, Middle, Last)	L	andscaper 18. Mothe	er's Name (First, Middle, M	Landsca	ping
yland buid be file Mental Hy	arked o	To Be	Marion	Wilkerson,	Sr. An	nie	Creel	
Mar nd 2 sho	27 is m r traum		19a. Informant's Name/Relationship (Type, Print, Robert Wilkerson/E		Solomons I:			Zip Code) MD 20736
Saltimore, bermit. Pages 1 al	nt: If item ry or othe		20a. Method of Disposition 1 Surial 2 Cremation 3 Removal f 4 Donation 5 Other (Specify)	rom State 20b. Place of Dispo- cemetery, cren Ernesti	sition (Name of natory or other place) neJonesCem.		Chesapeal	Town, State ke Bch., MD
Dantil. Departm	Importal eny inju once.		21. Signature of Funeral Service Licensee	22	Name and Address of Facility A 51 Dares Be	y Sewell Freach Rd.	uneral Ho	ome
150			23a. Part1. Enter the disease, or complications t shock, or heart failure. List only one cause	hat caused the death. Do not ento on each line.	- 0		JO 7 8	Approximate Interval Between Onset and Death
/M	sician edical		Immediate Cause (Final disease or condition resulting in death)	e to (or as a consequence of):	Attin	9		
Exa	miner	e	Sequentially list conditions, if any, leading to immediate	e to (or as a consequence of):				
ecuted	and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last	e to (or as a consequence of);				
68 / 60, ificate be executed	physician and s the burial-transit	edical E	d	e to (or as a consequence or).				
X 58 Sertifica	ding ph se as th		IF FEMALE: 23c If yes	s, outcome of pregnancy			1	
.C. BOX	been signed by the attending p should be detached for use as	hysiclan/M	in the past 12 months?	ive birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of del Month	Day Year
ords, P.O	igned b	by P	Part II. Other significant conditions contributing	to death but not resulting in the ur			acco use contribute to	the cause of death?
ecords law requires	s been s	ompleted				24a. Was an	24b. Were au	stopsy findings available
T e	certificate has rector, page 2	Com				autopsy perform	ied? death?	completion of cause of
OT VITAL	S E	To Be	25. Was case referred to medical examiner? 1 Tyes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outpatien	Other	e of Death <i>(Check only one</i> ursing Home 5 \to Resider		cify)
	fter th		27. Manner of Death 28a. I	Date of Injury 28b. Time of Injury Injury	28c. Injury at Work? M 1 Yes 2	28d. Describe ho	w injury occurred	.,
≥ ₹ ₹	irec n by	Certification:	2 Could not be	Place of Injury - At home, farm, strongillating, etc. (Specify)			eet and Number or Ru , State)	ural Route Number,
e Hospita	To the Funeral D completely filled in	ledical C	(Check only 2 Medical Examiner: On t	to the best of my knowledge, death the basis of examination and/or inv manner stated.	occurred at the time, date an vestigation, in my opinion, dea	nd place, and due to the ca ath occurred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
To th	To the	Me	29b. Signature and title of certifier	Hrw?	29c. License number	V35- 29	d. Date signed (Monti	h, Day, Year)
3			30. Name and address of person who completed Mukesh Mathur, N			rince Frede	erick, MI	20678
- ×	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 0 2005	32. Registrar's Signature	K)			

,,	•	4	For State Registrar	State of I	Marylan		artment of rtificate o				iene 2	005	03600
	Physicia /Medic	n al	1. Decedent's Name (First, Middle	Micha		o'n Wi				2. Date of Deat Month January	28, 2		3. Time of Death 12:00 noon
	Examin	er	4a. Facility Name (If not institution University of M 5. Social Security Number	aryland Med	•		4b. City, Town Balt If Under 1 Yea	imore	24 Hrs. 1	8. Date of Birth		unty of Death N/	A place (State or Foreign
	Funeral Director		215/42/4089 Usual Residence of Decedent	1 ∆ M 2□ F	60	Yrs.	Months Day		Min.	May 20,	1944	Mai	y land
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. American T is marked other than "natural", or Items 23a or 28a-f show other traumatic event, I'lly Madical Examinat must be notified at	Funeral Director	Maryland Washi 10e. Street and Number Bittersweet		10c. Cit	y, Town or Lo	Ha-	gersto 21740	Wn	11	U.	of What Cou	
9600	hours after dea tural', or Items al Exantiner mi	þ	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Xiproced	12. Was Decede Armed Forci ied 1 ☐ Yes 2 If Yes, Give Year or Date	es? 【∏ No		Was Decedent of If Yes, specify Control of Image 2 1 No. 1 N	lo Specify			Spe	Race - Ameri Black, White ecify: Wh	etc. nite
C	should be filed within 72 and Mental Hygiene. s marked other than "nat umatic event, the Medici	e Completed	(Specify only higher Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle,	College (1-4	or 5+)	(Give	kind of work dor DO NOT use ret	ne during mos red) al Off	icer	g (First, Middle, M	P	rison	
Maryland	2 should be and Mental is marked of sumatic even	To Be	James H. W			19b. Maili	ng Address (Stre	et and Numb		na Jone Route Number,		own, State, Zi	p Code)
e, M	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or othar tra once.		Paul A. Wilson 20a. Method of Disposition 1 Burial XIXCremation 4 Donation 5 Other (S 21. Signature of Funeral Service	3 □Removal from St pecify)	ate c	Place of Dispo cemetery, crea thsbur	atlin Sosition (Name of matory or other posteror) g Crema 2. Name and Ado	tory dress of Facil	Februa 20 lity J	ary 1, 005 Si .L. Dav	20c. Locati miths is :Fu	burg, neral	Maryland
	Pnysician /Medical Examiner	_	23a. Part Fater the disease, or enock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	aDue to (or	h line.	h. Do not en	ter the mode of o	<u>-</u>				nary i	Approximate Interval Between Onset and Death
8760, <	cate be executed bhysician and the burial-transit	dical Examiner	Cause. Enter Underlying Cause (Lissas) or mury that initiated events resulting in death) Last	C	as a conseq								
O. Box 68	that the death certificate be ted by the attending physic detached for use as the b	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2∏Feta nt at time of c	al death 3	⊒Ectopic pregna ⊒ Other (specify)		-		23d.	. Date of deliv Month	rery Day Year
ecords, P	v requires tha been signed should be del		Part II. Other significant conditi	ons contributing to dea	th but not res	sulting in the u	underlying cause	given in Part	l.	23e. Did tob	9S 2 N	/ lo 3 □ Pro	the cause of death? bably 4 □Unknown opsy findings available
of Vital Rec	Physician: The law this certificate has t ral director, page 2 s	Be Completed	25. Was case referred to medica examiner?						ce of Death	autops	med? 2 🗆 No	prior to codeath?	ompletion of cause of
Division of	or Attending Phys tter death. Director: After this in by the funeral dir	Certification; To	1 Pyes 2 No 27. Manner of Death 1 Ngtural 5 Pendii 2 Accident invest 3 Suicide 6 Could 4 Homicide determ	28a. Date of (Month, gation not be pined 28e. Place of	Injury Day Year)	28b. Time of Injury 10.45	of 28c. Jr	njury at Vork? □ Yes 2\	2/No R	City or Town	treet and No. State)	Courred MDD Fo	
	the Hosin 24 h the Fur npletely	edical	(Check only 2 Medical X	ng Physician: To the b Examiner: On the bas and manne	est of my kno is of examina ir stated.		nvestigation, in m	y opinion, de	ath occurre	d at the time, d	ate and pla	ace, and due	to the cause(s)
	with	2	▶ Mounte	be that	L WW of death (Ite) m 23a) (Type		O.C.I				ary 29	
	Sta Regist		31. Date filed (Month, Day, Year		gistrar's Sign	ature	Penn St	creet,	Balti	imore, 1	Maryla	and 21	201
DH	(p	ıte ar	31. Date filed (Month, Day, Year	he hu who completed cause (3- KORS)	gistrar's Sign	111	Penn St	92 T. T.	М.Е.			ary	29

			For State Registrar	State of Ma		/ Depa		of He	alth an	d Mental Hy	-		03	601
ı	Physici		1. Decedent's Name (First, Middle, Las Jean Esther Yir	•						2. Date of D Month Januar	Day	Year 2005	3. Time (
	/Medio Examin		4a. Fecility Name (If not institution, give Frederick Memori	street and number)	al			own, or L	ocation of D		4c. Coun	ty of Death ederi		
	Funeral Director		5. Social Security Number 6. Social Security Number 6. Social Security Number 1 Secu	9X 7. Age □M 2፟ØF	e (In yrs. last 85	birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 I Hours N	lin. (Month, D	rth ay, Year) , 1919	9. Birth Cou Wash	place (State intry) ingto:	or Foreign
	e Maryland ta-f show	ctor	10a. State 10b. County Maryland Frederick	τ	10c. City, T Adams t		cation						10d. Inside (City Limits
	with the a or 28 be no	Dire	10e. Street and Number	•			10f. Zip C				10g. Citizen o	What Cou	intry?	
0036	d within 72 hours after deeth with the Maryland plene. Itaha: "naturelt, or iteme 23e or 28e-f show Itaha: "Sandrer nust be natified at	Funer	2625 Park Mill Roa 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 XX I If Yes, Give Year or Dates:	No	1	I□Yes 2	int of His y Cuban	Specify:	? (Specify Yes or Nuerto Rican, etc.)	Spec	ack, White ify: Wh	ite	
Maryland 21215-0036	within ane.	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 1 2		i+)	(Give	lent's Usual kind of work DO NOT use	done du	ion ring most of	working	16b. Kind of		ndustry	
א מ	ent,	a	17. Father's Name (First, Middle, Last)			ETT		1	8. Mother's	Name (First, Middl	Homema e, Maiden Suma			
ylar	0 0 0	To B	William Charleton							lizabeth				
Mar	d 2 sho th and 7 is mu treum		19a. Informant's Name/Relationship (19mary "Pixie" Middl		9.7					r <i>Rural Rout</i> e Num. e 1d, Penn				
	ges 1 and 2 should it of Health and Mer it item 27 is marke or other treumatic		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name	e of		Date	20c. Location			
Ē	mit. Pages extrement of crtent: If it injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		1	Olive	et Cem	eter	y 1/2	27/2005	Freder			
Baltimore,	permit. Page Department of Importent: If any injury or		21. Signature of uneral Service Lican	Bus	м0099	9 10	06 Eas	t Ch	urch	Keeney an Street, F	rederic	rd Fu k, MD	neral 217	
The state of the s	ate be executed Wedical Wedician and he burial-iransit	cal Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	a consequen	nce of):	nei Ost a	in P	erat	ia ive () lip	Franc	Interval Br Onset and	Death
99	ntificate ng phy s as the	edi	IF FEMALE:						$\overline{\Lambda}$	7/100				
O. Box	at the death certificat by the attending phy tached for use as th	Physician/M	23b. Was decedent pregnant in the past 12 mg/ms? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	of pregnancy 2 Fetal de time of deat	y eath 3 h h 5 h	Ectopic pre	cify)	otion	24a. We aut 1 Yes	23d. C	ate of delive Month	very Day	Year
ords, P	The law requires that the ste has been signed by the bage 2 should be detache	by	Part II. Other significant conditions of	ontributing to death b	ut not resultin	ng in the u	derivity car	C. C. V	r in Parti.	239. Dig	tobacco use co	-	the cause of	
		Completed				Medi	drew	Med		24a. We aut per 1 \(\triangle \triangle Yes	s an 24b opsy formed? 2 No	were autoprior to codeath?	opsy finding ompletion of 2 No	s available cause of
5	Physicien: this certificant all director, it	o Be	25. Was case referred to medical examiner?	Hospital:	ent 2 TFF	NOutpatien	nt 3□ DOA	Other	26. Place of	Death (Check only ng Home 5 ☐ Re	one)	ther (Speci	ifv)	
Division of	ttending Phideath. ctor: After thi	Certification; T	27. Manner of Death 1 Staturel 5 ☐ Pending 2 Accident investigation	28a. Date of Inju (Month, Da Jan 18,	ry Year) 28	3b. Time of Injury	28	c. Injury : Work?		28d. Describe	how injury occ tim fell	urred Lwhi	le sta	
DIX	or A		4 ☐ Hornicide determined	building, et Nurs	ing Ho	me				Emmit	sburg,	31 So Maryl	uth S and	mber, eton
	To the Hospital within 24 hours a To the Funerel I completely filled	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example (Check only one)	ysician: To the best niner: On the basis o and manner st	f examination	edge, deat n and/or in	h occurred a vestigation, i	it the time in my opi	nion, death o	face, and due to the occurred at the time	e cause(s) and i e, date and place	nanner as e, and due	stated. to the cause	(s)
	To th within To th compl	Me	29b. Signature and title of certifier	~~~	MO			License	_	71	29d. Date sign	_ ^		
	6		SAJJAD AZ	completed cause of c	- 80	3a) (Type,	Print)	tou.	x A	11 Ive, F	rederie	l.m	D 2	1701
	Sta Regist	ate rar	31. Date filed (Month Pay (Yay)) 20	05. 32 Registr	ar's Signatur	50	ale							

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F			ene g. NZ 005	03602			
	Dhini		1. Decedent's Name (First, Middle, La	ast)		-		2. Date of Death Month	Day Year	3. Time of Death			
	Physici /Medio		JACI	ζ	ZIPPIN			JANUARY	19, 2005	4:00 PM			
	Examin		4a. Facility Name (If not institution, gi				r Location of Dea	th	4c. County of Dea				
			HOLY CROSS HOSP				SPRING	0.000	MONTGON				
	Funeral Director			Sex 7. Ag 1∏ M 2□ F	ge (In yrs. last birthday 90 Yrs.	Months Days	Hours Min		Year) 9. Bin 2007 1914 NEW	thplace (State or Foreign ountry) YORK			
	and and		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits			
	he Mary	Director	MD MONTGOI	MERY			LVER SPR			1 ☐ Yes 2 🛣 No			
	th with t		10e. Street and Number 3148 GRACEFIELD	ROAD APT.	222	10f. Zip Code	20904	10	g. Citizen of What Co U • S	S.A.			
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "neturel; or items 23e or 28e-f show event, the Medical Exercitivat cast be indiffied at	by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit Specify:	e, etc.			
21215-0036	"neturei	Completed b	15. Decedent's E (Specify only highest gi	ducation	(Giv.	edent's Usual Occup e kind of work done DO NOT use retire	during most of we		6b. Kind of Business	WHITE /Industry			
12	within ene. then "	ш	Elementary/Secondary (0-12)	College (1-4or	5+)	MARKET MA	-		FC	OOD			
land 2	buld be filed with Mental Hygiene. arked other the atic event, the	To Be Co	17. Father's Name (First, Middle, Las NATHAN ZIPPIN				18. Mother's Na	nme (First, Middle, M	aiden Sumame)				
Maryland	d 2 sho th and 7 is m treum	-	19a. Informant's Name/Relationship JEFFREY ZIPPIN -					Pural Route Number,	City or Town, State, 2	Zip Code) 20171			
45	ages 1 and 11 of Health 127: If item 27		20a. Method of Disposition 1 🔀 Burial 2 Cremation 3		1	ematory or other pla			Oc. Location - City or				
Ħ	artmer primer injury	1	* 4 □ Donation / 5 □ Other (Spec 21. Sign ture of Funeral Service List		And the second s	BRON CEME	The second secon		FLUSHIN				
Ba	permit. Pages 1 Department of H importent: If ite any injury or otl		1 Juny Dr.	Trin		1170 ROCK	VILLE PI	KE, ROCKV		INC. 20852			
	Fnysician /Medical Examiner		23a. Pay1. Enter the disease, or construct, or heart failule. List only immediate Cause (Final disease or condition resulting in death)	a. NON HO	d the death. Do not er ine. DGKINS LYM a consequence of):		ng, such as cardia	ac or respiratory arre	st,	Approximate Interval Between Onset and Death 6 MONTHS			
· ·	be executed sicien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. First this thin Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):								
38760,	icate be physicie s the bur	edical	•	d					-				
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) □	y		23d. Date of del Month	livery Day Year			
ds, P	uires that n signed b ld be deta	þ	Part II. Other significant conditions CONGESTIVE HEART		out not resulting in the	underlying cause gr	en in Part I.	23e. Did tob	acco use contribute to s 2 X No 3 ☐ Pr	the cause of death?			
Records,	ie ław requiri has been si ge 2 should I	Completed	ACUTE MYOCARDIAL	INFARCTIO	N			24a. Was an autopsy	prior to	utopsy findings available completion of cause of			
		e Co	OF Man one referred to medical					1 ☐ Yes 2	X No 1 ☐ Yes	2 No			
Vital	ysicien: is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2X No	Hospital:	ent 2 FR/Outpatie	ent 3 DOA Ott	105	eath (Check only one		cify)			
on of	ding Phy h. After this funeral c		Tall in parent 2 Ervouparient 3 Dox 4 Enviring notine 3 Energetical (Specify)										
Division	or Attending Physicien: after death. Director: After this certifica i in by the funeral director.	Certification;	3 ☐ Suicide 6 ☐ Could not	Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory office 28f. Location (Street and Number or Burst									
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical C											
.	To the within To the	Me	29b. Signature and title of cedifier	201-	aus	29c. Licens	se number 3224		d. Date signed (Mont				
7	3		30. Name and address of person who	completed cause of	death (Item 23a) (Type	, Print)	=	J	ANUARY 20	,_2005			
			RAM TREHAN, M.D.			IVE, SUIT	E #301	ROCKVILLE	, MD 2085	2			
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 1 2	005 Hegist	rar's Signature	ever							

		,		rtment of Health and M ificate of Death	Re	g. No. 2005	03603
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		Michell Lynn Arnold 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Februar	y 6, 2005 4c. County of Death	5:45 am M
			4 Nickel Court	Chase		Baltimore	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 XF 38	Months Days Hours Min.	8. Date of Birth (Month, Day, May 31,	Year) Cou	place (State or Foreign ntry) 7land
	D		Usual Residence of Decedent		May JI,		
	Aaryla Febov	ō	10a. State 10b. County 10c. City, Town or Loca	ation			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	r 28a-	Director	Maryland Baltimore Chase 10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	ntry?
	23a o	aiD	4 Nickel Court	21220		U. S . A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23e or 28e-f ehow any injury or other traumatic event, the Madical Exanterer must be indified at ance.	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 1 9 2 1 0 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto f Yes 2K No Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify:	
2	72 hou natura	sted	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give ki	ont's Usual Occupation ind of work done during most of work in	1	6b. Kind of Business/Ir	
Maryland 21215-0036	within ane. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 1.2 Manage	O NOT use retired)		State Highw Administrat	vay
9	Hygie other	Be Co	12 Manage 17. Father's Name (First, Middle, Last)	18. Mother's Name			
ylar	should be ind Mental imarked o	To B	James Joseph Preston	Sandy Eli	zabeth i	Adey	
Mar	d 2 shoth and 7 is m			Address (Street and Number or Rura			Code)
	s 1 and f Health itam 27 other to		20a. Method of Disposition 20b. Place of Disposit	kel Court Chase,	Maryland	0c. Location - City or T	own, State
<u>=</u>	Pages ment of I ant: If its ury or o		1 ☐ Burial 2 🖔 Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Bayview Cr	1 2//	, 15]	Baltimore (City, MD
Baltimore,	permit. Departr Imports any inju		Michael C. Delfron Dr. 140	Name and Address of Facility 12dziński Funeral 07 Old Eastern Ave	enue Es		and 21221
	Pnysician /Medical Examiner	10	23a. Part1. Enter the disease, or omplications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	r the mode of dying, such as cardiac of	respiratory arre	st, -	Approximate Interval Between Onset and Death 3 Months
68760,	tificate be executed ig physician and as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last c				
.O. Box	death cer e ettendir id for use	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 1 □ Ves 2 No 9 □ Unknown	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
rds, P	sign sign d be		Part II. Dther significant conditions contributing to death but not resulting in the und	derlying cause given in Part I.	23e. Did toba	acco use contribute to t	
I Reco	The taw ate has b page 2 st	Completed	Hypophosplatenia		24a. Was an autopsy perform	prior to co	opsy findings available impletion of cause of 2 No
Vita	Physician: The ir this certificate har all director, page	Be	25. Was case referred to medical examiner?	26. Place of Death	7.7		
Division of Vital Record	Jing Ph J. After th funeral	ation: To	27. Manner of Death 1 Inpatient 2 Et/Outpatient 28a. Date of Injury 2 Accident Investigation 28a. Date of Injury	3 DOA 4 Nursing Hon		nce 6 □Other (Speci vinjury occurred	(y)
Divis	tal or Attencts after death	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	et, factory, office	8f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Diract completely filled in by	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the best of the best of my knowledge, death of the best of the best of my knowledge, death of the best	occurred at the time, date and place, a estigation, in my opinion, death occurre	nd due to the cau d at the time, da	use(s) and manner as s te and place, and due t	stated. the cause(s)
}	To the To the To the Complet	2	29b. Signature and titlg of certifie \mathcal{D} . \mathcal{M} . \mathcal{M} . \mathcal{M} . \mathcal{D} .	29c. License number D 005 49 11	29	d. Date signed (Month,	Day, Year) 7 - 2005
	, 0		30. Name and addess of berson who completed cause of death (Item Ba) (Type, P. O. C. C. C. 24 31. Date filed (Month, Day, Year) 32. Registrar's Signature	D0054911	re Ave	- BAHim	PRE MD 21215
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 8 2005				

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 0 5 0 3 6 0 4
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)
	Examin Funeral Director		5. Social Security Number 6. Sex 1 M 2 M F 94 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Min. Oct. 7, 1910 N/A 9. Birthplace (Stete or Foreign Months) Days Hours Min. Oct. 7, 1910 Maryland
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Howard Ellicott City 11 ☐ Yes 2 ☐ No
	an or 28a	Direc	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9210 Winding Way 21043 U.S.A.
36	hours after death with the Maryland tural; or Items 23a or 28a-f show al Examiner must be multiled at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 13. Was Decedent of Hispanic Origin? (Specify Yes or Nollif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No Specify: Specify: White
21215-0036	in 72 n na	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Clerk D.M.V.
Maryland 2	ould be filed with I Mental Hygiene. Parked other that	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Francis Klauzowski Anna Plocharski
	ss 1 and 2 sho of Health and item 27 is mu other traums		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly D. Henderson(Daughter) 9210 Winding Way Ellicott City Maryland 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State
Baltimore,	permit. Pages Department of Important: If it any injury or o		Holy Cross Cemetery 2/7/05 Brooklyn, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MCCull V-Polyniak Funeral Home, P.A.
	Physician /Medical Examiner	Examiner	3204 Mountain Road Pasadena, Maryland 21122 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on such line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):
.O. Box 68760,	The law requires that the death certificate be execut ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran	Completed by Physician/Medical Ex	Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
٥.	w requires that the bean signed by should be detact	eted by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available
Vital Records,	ysician: The law is certificate has I director, page 2 s	0	autopsy performed? death? 1 □ Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one)
Division of Vi	ding Ph J. After th funeral	To B	examiner? 1 Yes 2 I/No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 5 Pending (Month, Day Yeer) 2 Accident investigation 1 Yes 2 No
Divis	ital or Attend rs after death ral Director: /	Certification:	
	To the Hospital or Attendwithin 24 hours after death To the Euneral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	A		De la completa carred dante (Ham 23a) (Typa Print)
	St Regist	ate	Ming Vi 3320 bension Avenue Baltimore Maryland 21227 31. Date filed (Month, Day, Year) FEB 08 2005 September 18 Aprel 19 19 19 19 19 19 19 19 19 19 19 19 19

05-00802 B.K.S ROGER G. BARTRUG

			State of Marylar State of Marylar 23a&27 per me	G840	partment of F 2-05 ta ertificate of	beath			ene 2005	
	Physici		1. Decedent's Name (First, Middle, Last) Roger G. Bartrug				l N	ate of Death Month AN. 31	L, 2005	3. Time of Death $10:00A^{-M}$
	/Medio Examin		4a. Facility Name (If not institution, give street and number) 7942 CLARK ROAD ROOM #22		4b. City, Jewas S	Location			ANNE AR	
8	Funeral Director		5. Social Security Number 6. Sex 7. Age (<i>In yrs.</i> 163–58–8487	V	y) If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. D. (//	ate of Birth Month, Day, Y V 15,	9. Bi 1960 Wes	rthplace (State or Foreign Sountry) St Virginia
~)	the Maryland 28a-f show	Director	Usual Residence of Decedent	ity, Town or		ssup		1.10-	- CW	10d. Inside City Limits 1 ☐ Yes 2X No
	N with 13a or	DI	7942 Clark Road, #22		207	794		109	i. Citizen of What C USA	ountry?
036	72 hours after death with the Maryland natural', or iteme 23a or 28a-f show dical Examitrer must be motified at	by Funerai	11. Marital Status 1 □ Never Married 2□ Married 3 □ Widowed 4 ☒ Divorced 12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 □ XNo If Yes, Give Y Year or Dates:	J.S. 13	B. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No			Yes or No- n, etc.)	14. Race - Am Black, Wh Specify:	
1215-0	within 72 ho ane. then "natur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. De (Gi life	cedent's Usual Occup ye kind of work done . DO NDT use retired Engineer	during mos d)	st of working	16	Combana	
Maryland 21215-0036	uld be filed Mental Hygi Irked other Itic event, II	To Be Co	17. Father's Name (First, Middle, Last) Michael J. Bartrug		Engineer	18. Moth	er's Name (Firs		Contract iden Surmarne) son	Tug
re, Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f show any Injury or other traumatic event, Ite Modical Examitrational by notified at once.			112	iling Address (Street 35 Peartre position (Name of rematory or other place	ee Way		E, Co	City or Town, State, Lumbia M c. Location - City o	D 21046
Baltimore,	permit. Page Department of Important: If any Injury or once.		4 Donation 5 Other (Specify) 21. Signature Fun ral Service Licensee	•	rematory, ^{22 Name and Addre Cremation 299 Frede}	Inc		MD, II	Baltimor	re, MD
	402 6 0		Edward A. Gregorchik 23a. Part1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line.	th. Do not e	299 Frede	erick ng, such as	Road B	altímo: piratory arrest	re, MD 21	Approximate Interval Between
58760, <i>‡</i>	Physician /Medical Examiner b physician and physician and physician are the prinal-transit.	edicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any Learny 1 mmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consect of the conditions) of the conditions of t	quence of):	galy					Onset and Death
P.O. Box	w requires that the death certifi been signed by the attending I should be detached for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of constitutions of the pregnant at time of the pregnant at time of constitutions of the pregnant at time of the pregnant at time of the pregnant at time of	al death	E Ectopic pregnancy	,			23d. Date of de Month	olivery Day Year
	equires that sen signed b ould be deta		Part II. Other significant conditions contributing to death but not res	sulting in the	underlying cause giv	en in Part I	. 2		cco use contribute t	o the cause of death? robably 4 Munknown
al Reco	≥ □ ਯ	Completed					1	24a. Was an autopsy performed Yes 2	d? prior to dea/h?	utopsy findings available completion of cause of s 2 \(\text{No} \)
Division of Vital Records,	ending Physician: The laveath. or: After this certificate has the funeral director, page 2	ertification; To Be	25. Was case referred to medical examiner? **DCX** es 2 \sum No 27. Manner of Death 1 \times Natural 5 \sum Pending investigation 28a. Date of Injury (Month, Day Year) investigation	ER/Outpat 28b. Time Injury	of 28c. Injur	er: 4□Nu	28d. [5 🗆 Residenc	e 6 X Other (Speinjury occurred	acify) AT SCENE
Divis	To the Hospital or Attending within 24 hours after death. Jo the Funeral Director: Atter completely filled in by the funer	0	3 Suicide 6 Could not be determined 28e. Place of Injury - At h building, etc. (Special Coulding)	fy)				City or Town, S	State)	tural Route Number,
	ne Hos	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my kno (Check only one) 2 ☐ Medical Examiner: On the basis of examina and manner stated.	owledge, de ation and/or	ath occurred at the fin investigation, in my o	ne, date an pinion, dea	nd place, and di ath occurred at	ue to the caus the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	200.	29c. License 0.C.				FEB. 1,	
	Balin	te	30. Name and address of person who completed cause of death (Iter A Could Political 31. Date filed (Month, Day, Year) 32. Registrar's Signa	1 11 P	e, Print) ENN STREET	, BAL	TIMORE,	, MARYLA	ND 21201	
	Registr	ar			1.0					
DH	MH 17 Rev 1/2	001	FEB 0 8 2005	ORIGI	AL					

			For State Registrer AMENI) ITEM			_					nd Me	ental Hyg R	iene	005	03606	
	Physici /Medic		1. Decedent's Name (First	, Middle, La	st))			,,	Bo	ich+	-	2. Date of Dear Month	Day	Yea	1	1
	Examin		4a. Facility Name (If not in	stitution, give		Umber)	465		4b. City,	Town, or	Location o			78	County of De		_
	Funeral Director		5. Social Security Number 216-24-8986 Usual Residence of December 1	1	ex □M 2 ½ F	7. Age ((In yrs. last bii 74	rthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day) Jul 11,	Year)		irthplace (State or Foreign Country) MD	n
	aryland show	10	10a. State 10b.	County	1/4	1	10c. City, Tow	n or Lo	ocation							10d. Inside City Limits	
	h the M r 28a-f	Director	Maryland 10e. Street and Number	ľ	N/A				10f. Zip		ltimore		1	0g. Citiz	en of What (1	_
	s 23a c		1400 Madison	Street	1						2121					S.A.	
920	172 hours after death with the Maryland "natural", or items 23a or 28a-1 show officel Expoliter nust be notified at	by Funerai	11. Marital Status 1 Never Married 2 3 Widowed 4 D		12. Was Dec Armed F 1 Tyes If Yes, G Year or	Forces? 2 □ No Sive		'	Was Deced If Yes, spec 1 ☐ Yes	offy Cuban	panic Orig , Mexican Specify:	jin? (Spec , Puerto Ri	ify Yes or No- can, etc.)		4. Race - An Black, Wh Specify:	nerican Indian, nite, etc. Black	
12-0	72 ho	eted	15. D (Specify only	ecedent's Ed highest gra	ducation de completed)	16a	(Give	dent's Usua kind of wor	rk done di	tion uring most	of working	7	16b. Kin	d of Busines	ss/Industry	
Maryland 21215-0036	withir ane. than	Completed	Elementary/Secondary	(0-12)	College	(1-4or 5+))	ife.	DO NOT us		emaker				Owi	n Home	
and		Be	17. Father's Name (First, i		n Dixon						18. Mother	r's Name (First, Middle, I	Maiden S			
aryl	de la maria	2	19a. Informant's Name/Re				196	o. Mailir	ng Address	(Street a	nd Numbe	r or Rural i	Route Number			, Zip Code)	_
	s 1 and 2 of Health a item 27 ls other trai		Catherine Hartf				20b. Place o				treet Ba	altimore	, Maryland				
Mor	Se jo		20a. Method of Disposition 1 DiBurial 2 Crer 4 Donation 5 0	nation 3		n State	cemete	ry, crer	natory or o	ther place		0	2/15/05			or Town, State	
Baltimore,	permit. Page Depertment of Importent: if any injury or once.		21. Signature of Funeral	-			Carriso		2. Name an Es	d Address step Br	of Facility	, Funera	I Home P.	Α.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
			23a. Part1. Enter the dise shock, or heart failur	ase, or com re. List only	plications that one cause on	caused the	ne death. Do	not ent	er the mod	e of dying	taw Pla , such as o	ce Bal cardiac or	timore, MI respiratory arr) 212 est,	1/	Approximate Interval Between	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				consequence		onar	4	Acc	455				Onset and Death	_
	Examiner	_	Sequentially list condition	s,	b. Ch	(00)	ic R	60	al F	ail	ure					3 Minute	6
	uted d ansit	Examiner	if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	4		STROK	consequence	otj.									
.09	ficate be executed physician and s the burial-transit		resulting in death) Last	- [consequence	of):					-				
68760,		Medicai	IF FEMALE:		_ d												
O. Box	law requires that the death certiff as been signed by the attending 2 should be detached for use as	Physician/M	23b. Was decedent pregr in the past 12 month 1 ☐ Yes 2 ☑ No 9 ☐ Unknown			birth 2 gnant at tir	pregnancy Fetal death me of death		Ectopic pro Other (sp.					23	3d. Date of d Month	lelivery Day Year	
ds, P	ires that the de signed by the a d be detached to	þ	Part II. Other significant of	conditions o	ontributing to	death but	not resulting i	n the u	nderlying ca	ause givei	n in Part I.	****				to the cause of death?	1
Records,	law require as been si 2 should b	Completed									****	-	24a. Was a	n	24b. Were	autopsy findings available	_
al Re	The ate h page	Com											autops perform 1 Tes 2	ned?	death?	completion of cause of es 2 🗷 No	
Vital	Physicien: this certific ral director,	o Be	25. Was case referred to examiner? 1 ☐ Yes 2 ☑ No	medical	Hospital:	Inpatient	2 ☐ ER/O	itnatied	nt 3 🗆 DO				Check on on 5 ☐ Reside		□Other (Sr	nacihi)	
on of	ling After une	tion: T	27. Manner of Death	Pending investigation	28a. Date (Moi	*	28b.	Time of Injury		8c. Injury Work	at es 2 1	28	d. Describe ho			outy/	
Division	ei or Attendi s after death. I Director: A d in by the fu	Certification:		Could not b determined	286. Plac	e of Injury ding, etc.	y - At home, fa (Specify)	am, str	reet, factory	, office		28	f. Location (St City or Town	reet and , State)	Number or I	Rural Route Number,	_
	To the Hospitel or a within 24 hours after To the Funerel Dire completely filled in b	edicai C	29a. Certifier 1(2x) Coneck only one)	ertifying Ph ledical Exam	niner: On the	ne best of basis of e nner state	xamination ar	e, death	n occurred vestigation,	at the time in my opi	o, date and nion, deat	place, an	d due to the ca at the time, da	use(s) a ate and p	and manner a place, and du	as stated. ue to the cause(s)	
	To the within 2 To the complet	W	29b. Signature and title of	certifier	CM ,					. License						nth, Day, Year)	
1	1.50	9	30. Name and address of	person who		use of dea	ath (Item 23a)	(Type.	Print)	39	221		F	ebr	many	7,2005	
4	(1			alette	JM, O	> 4	1940	Ea	ster	A	we.	, B	altim	970	, MD	21224	
1	Sta Registr	. 9	F.F.				s Signature										

			1 - For State Registrar	State of Ma		epartment of F Certificate of		nd Mental Hy	gienez (105	036	07
			1. Decedent's Name (First, Middle	, Last)				2. Date of De			3. Time of	Death
	Physici /Medio		Kikue	Kojima Bi	ryant			Februa	arv 4. 2	Year 2005	7:00	P^{M}
	Examin		4a. Facility Name (If not institution	, give street and number)		4b. City, Town, o	r Location of I			ty of Death	, , , , ,	
			732 Cotter Roa	ad		Glen	Burnie		Anne	e Arun	nde1	
	Funeral		5. Social Security Number	6. Sex 7. Ag 1 M 2 X F	e (In yrs. last birtho	Months Days	If Under 24 Hours	Hrs. 8. Date of Bi	rth av. Year)	9. Birthp	place (State or	Foreign
	Director		135-28-4357	1 П М 2 <u>Б</u> Д Р	77 Yrs	3.		SEP 13		Jap		
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				1	0d. Inside Cit	v Limits
	Aaryl sho	ō		Ammdal	, , , , , , , , , , , , , , , , , , , ,					'	1 Tyes	·
	289-1	ect	10e. Street and Number	Arundel		Glen Bu	rnie		10g. Citizen of	What Cau		
	with Be or	ā	732 Cotter Roa	ad			060		_	JSA	III y r	
	leath	Funeral Director	11. Marital Status	12 Was Decedent	Ever in U.S.			2 (Specify Yes or N		JOA ace - Americ	an Indian	
	ritar	Fun	1 ☐ Never Married 2 ☐ Marri	Armed Forces? ned 1 ☐ Yes 2 🔼 h	No	13. Was Decedent of F If Yes, specify Cuba		Puerto Rican, etc.)	Bla	ack, White,		
3	ali, o	by	3 ☐ Widowed 4X Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 📉 No	Specify:		Spec	fy: A	sian	
	72 ho	Completed	15. Decedent (Specify only highes	t's Education	16a. De	ecedent's Usual Occup	ation	f working	16b. Kind of I	Business/Inc	dustry	
-	thin 7	pje	Elementary/Secondary (0-12)	College (1-4or 5	5+) (C	ive kind of work done e. DO NOT use retired	d) d)	r working				
7	or th	Son	12			Seamstress			Garmer	it Ind	lustry	
3	2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. Is marked other than "natural", or items 23s or 28e-f show raumatic evant. It's Medical Examiner runt be notified at	Be (17. Father's Name (First, Middle,				18. Mother's	Name (First, Middle	, Maiden Suma	me)	-	
y	Ment Ment arke	၉	Nisaburo Koj	jima			Kuni	UNK.			_	
0	2 she and is m		19a. Informant's Name/Relations			ailing Address (Street		or Rural Route Numb	er, City or Town	ı, State, Zip	Code)	
2	and ealth n 27		Evelise A. Bou	idreaux/Daugh		1 220th St	reet 1	Pasadena,				
ב כ	Pages 1 nent of Hi int: If iter		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation	3 □Removal from State	20b. Place of Di cemetery,	sposition (Name of crematory or other place	се)	Date	20c. Location	· City or To	wn, State	
	Pag ment ant: ury		`4 □ Donation 5 □ Other (S)		Metro C	rematory,			Balti	more.	MO	
<u></u>	permit. Departr imports any inju		21. Signature of Funeral Service	Licensee		22. Name and Addre	ss of Facility	v of MD.	Inc			
_	20529		Edward A.	Gregorchik		299 Freder	rick Ko	oad Baltim	ore. Mr	2122	8	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lin	the death. Do not	enter the mode of dyin	ng, such as ca	rdiac or respiratory a	rrest,		Approximate Interval Betw	reen
	Physician		Immediate Cause (Final disease or condition	Mo	tastal	4. Tune	1 (0	Mark			Onset and D	eath
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	1 2 1	a					
	Examine		Sequentially list conditions,	b. he	perca	Desteir	Corne	2)				
	pi sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	consequence of):							
	ecut and -tran	Examiner	that initiated events resulting in death) Last	C	a consequence of):							
2 2	cate be executed obysician and the burial-transit			Due to (or as	a consequence or,							
2	cate physi the	dici		d						- 11		
<	The law requires that the death centificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:	23c. If yes, outcome	of pregnancy				22.5			
ב	es that the death cer igned by the attendir be detached for use	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	,		1	ate of delive onth	*	ear
5	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	time or death	5 Li Other (specify)						
	that the ed by detail		Part II. Other significant condition	ons contributing to death b	ut not resulting in th	e underlying cause giv	en in Part I.	23e. Did 1	obacco use cor	ntribute to th	e cause of de	ath?
2	sign d be	d by			_	, , ,		1 🗆	Yes 2□No	3 🗀 Prob	ably 4 □Ur	nknown
Ş	w requir been si should I	ete										
	has ge 2	Completed						— 24a. Was		prior to con death?	psy findings a npletion of ca	vallable use of
	n: Th icate r, pag							1 ☐ Yes	2 Y No		2 🗆 No	
	sicien: The law s certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		Oth		Death (Check only				
5	Phys this ral di	- To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatie				ng Home 5 Resi	dence 6 ⊡Ot how injury occu		/)	
5	ding P. h. After funera	ion	1 Natural 5 ☐ Pending	g (Month, Day	Year) 280. Inju	ry Wor	yat k? Yes 2⊡No		now injury occu	ried		
2	deat deat ctor: y the	ica	2 Accident investig	not be One Place of Inju	uny - At home farm	street, factory, office	103 2		Street and Num	her or Pura	l Poute Numb	100
2	after after Dire	Certification:	4 Homicide determine	building, etc	c. (Specify)	street, factory, office		City or To	wn, State)	Del Ol Rula	r rigote i votilio	01,
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifyin	g Physician: To the best	of my knowledge d	eath occurred at the tin	ne date and n	place, and due to the	cause(s) and m	anner as st	ated	
	24 h	edical	(Check only 2 Medical I	Examiner: On the basis of and manner sta	examination and/o	r investigation, in my o	pinion, death	occurred at the time,	date and place,	and due to	the cause(s)	
	o the ithin o the omple	Me	29b. Signature and title/of certifier		1 1	29c. Licens	e number		29d. Date signe	ed (Month, I	Day, Year)	
	⊢ s ⊢ ŏ		11/1	X K.h.	ulla.	1 150	(1) 71		Februa			
	\wedge		30. Name and address of person	who completed cause of d	eath (Item 23a) (Tu	ne Print)'	000			-, -,		
	. /		7895 (7770	Dos C+	POAL B	1111111	(10) 3	2/060	Chi	Moina	11:1	Sec.
	Sta	te	31. Date filed (Month, Day, Year)	32. Reĝistro	ar's Signature	wire /		1000	Till	115115	L 1 1 1	IUI ()
	Registr	_	FFB 0	8 2005	to be	Acres -						
-			- to to		- A - A - A - A - A - A - A - A - A - A							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Melina Bezirdjian bruar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HGNE Security Number HEALTHCARE N/A 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🛣 F Months Days Hours 212-29-4529 Director 87 OCT 16. Turkey Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland N/A<u>Baltimore</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 3320 Benson Avenue 21227 Funerai USA ltams ; 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No Specify: Completed by Specify: White 3 X Widowed 4 □ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7:
Deportment of Health and Mental Hygiene.
Important: if item 27 is marked other than "na any njury or other traumatic evant, If a Maric 2005. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ျှ Setrak Keropian Araxie Bouldoukian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diran Bezirdjian/son 504 Walsing Drive Richmond, VA 23229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 2/9/05 Metro Crematory, Inc. Baltimore, MD 21. Signature of Funeral Service Lichae ²²Clame and Address of Facility of Maryland, Inc. Thomas Gregor 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Proysician HIMONY. Z /Medical Due to (or as a consequence of): **Examiner** XIO Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due t (as a consequence of): Examiner ACTO ON C Due to (or as a consequence of): the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1 Tes 2 X No in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred : After or Attanding 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral I 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MID

State Registrar AMJAD

31. Date filed (Month, Day, Year)

FEB 0 8 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Special Control of the C

State of Maryland / Department of Health and Mental Hygiene | 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 10:29 PM February 5, Henry George 2005 Boru /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Center Baltimore Rosedale If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 31, 1919 Birthplace (State or Foreign Country)
 Marykand 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1**∑**M 2□F 85 Director 212-07-8688 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other then "neturel", or items 23s or 28e-f show other treumetic event, I've Modical Examinar must be notified at 1 ☐ Yes 2 ▼No Director Parkville Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8800 Walther Blvd., Rm 2102 21234 u.s.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Tes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White Completed by 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Self-Employed of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Owner Seafood Deli 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Henru Boru Maru Nosh 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Edward J. Bory 6615 Hudson Street, Baltimore, MD (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of Importent: If it eny injury or o 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 Ø Other (Specify) Entombment St. Stanislaus Maus. 2/10/2005 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician **Physici** Fibrillation Ventricular 1 min-te disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner ASCVD 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by tibrillation 1 Yes 2 No 3 Probably 4 Unknown Chstructive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an filled in by the funeral director, page 2 autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier William Mr. D30182 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARTHER BLUD BALTIMORE RUSSELL MD 00 H WILLIAM M . Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 8 2005 Registrar

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Mary		ertificate of D			ene 9. N2 0 0 5	03610
Dhusia		1. Decedent's Name (First, Middle, L	ast)	-7			2. Date of Deat		3. Time of Death
Physic /Medi		Mary Ellen Bowi				,	Januar	1	
Exami	ner	4a. Fecility Name (If not institution, gi Doctor's Hospit	•		4b. City, Town, or l Lanham	Location of Death		Prince (
Funeral	_		Sex 7. Age (In	yrs. last birthda		If Under 24 Hrs. Hours Min.	8. Date of Birth	9 Rid	hplace (State or Foreign
Director		578-58-4390	1□ M X□ F 61	Yrs.	Wioritis Days	Tiours Iviiri.	Jan. 28,	1944 Mc	vrýland
land DW		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or	ocation				10d. Inside City Limits
Mary a-1 sh	to	MD Princ	e George	Bowie					1 ☐ Yes 2 ☑ No
ith the Marylan or 28a-f show	Oirec	10e. Street and Number			10f. Zip Code		10	ng. Citizen of What Co	untry?
s 23a	rail	12808 Brunswick	Lane 12. Was Decedent Ever	in H S 13	20715	ranio Origin? /Sa	acity Vac or No-	USA 14. Race - Ame	rican Indian
tter de	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces? 1 Yes 2 No If Yes, Give	III 0.5.	. Was Decedent of His If Yes, specify Cuban		Rican, etc.)	Black, Whit	e, etc.
ral', or	þ	3 ☐ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: U	Ihite
ified within 72 hours after death with the Maryland Hygiene. Hygiene. Street then "netural", or Items 23a or 28a-1 show ent. The Medical Examination motified at	Completed	15. Decedent's (Specify only highest g	Education rade completed)	16a. Dec	edent's Usual Occupat re kind of work done du DO NOT use retired)	tion uring most of work	ing	16b. Kind of Business	Industry
withir lene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		retary			Federal (Bovernment
e filled II Hyg other	Be C	17. Father's Name (First, Middle, Las				18. Mother's Name		Maiden Sumame)	
Menta Menta arked	To	Samuel S. Lohr,					Mary Gr		
VIGIT 12 sh h and 7 is m traum		19a. Informant's Name/Relationship Kelly Cordero /			iling Address (Street ar			•	zip Code) Irginia 23453
Healt Healt tam 2		20a. Method of Disposition		Oh Place of Die	nosition (Name of			20c. Location - City or	
polition (e), Mary yearing 2 12 13 13 13 13 13 13 13 13 13 13 13 13 13		1 ☐ Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spec	□Removal from State 1	Balt/Was	ematory or other place h Cremator	_		Laurel, Ma	-
ermit. Pag epertment nportant: ny Injury one		21. Signature of uneral Service Lic			22. Name and Address			eral Home,	
205.02	_	23a. Part1. Inter the Isease, or co	molications that caused the		7601 Sandy				Approximate
Discolution	ı	shock, or heart fillure. List on Immediate Cause (Final	y one cause on each line.	IRA	TARY		LURG		Interval Between Onset and Death
Physician /Medical	ı	disease or condition resulting in death)	a. Due to (or as a co	onsequence of):	101-1	(, ,) 6	002		7040
Examiner		Sequentially list conditions,	b. CND	ST	AGE	COP	D		>2 years.
led Isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):	ARR.	H47H1	MIAS	2,	
executor and ial-trai	Examiner	that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of):	* / /				
ficate be executed physician and as the burial-transit	edicai		d						
		IF FEMALE:	23c. If yes, outcome of p	regnancy				22d Dalo of do	in one
DOX leath cer attendir	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death	Ectopic pregnancy			23d. Dale of de Month	Day Year
ecords, P.O. box of law requires that the death certif as been signed by the attending 2 should be detached for use a	Physician/M	9 Unknown	9□ Unknown						
S, T es tha igned be de	þ	Part II. Other significant conditions	contributing to death but n	ot resulting in the	underlying cause give	n in Part I.		pacco use contribute lo	the cause of death?
ecords, law requires as been signo	eted						-	7	, –
The law	Completed						24a. Was a autops perform	y prior to death?	ompletion of cause of
VICIAN: The certificate rector, pa	0	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes A		2 No
OT VITA Physician: r this certific ral director,	To B	examiner? 1 Tes 2 SNo	Hospital: 1 Inpatient	2 SER/Outpat	Otho	-		nce 6 Other (Spe	cify)
ing Phy Mer this		27. Manner of Death 1 ★ atural 5 Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time	Work	?	28d. Describe ho	w injury occurred	
INISION I or Attending after death. Director: After the function by the function	ertification:	2 Accident investigat 3 Suicide 6 Could not	be Riggs of Joines	- At home, farm,		'es 2 □No	28f. Location (St	reet and Number or Ri	ural Route Number,
DIVISION OT VITAL MENTION TO THE INC. To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certii	4 Homicide determine	building, etc. (Specify)	,,		City or Town	, State)	
lospita hours unera	edical (29a. Certifier 1 Sertifying (Check only 2 Medical Ex	Physician: To the best of marriner: On the basis of ex	ny knowledge, de amination and/or	ath occurred at the timi	e, date and place, inion, death occur	and due to the ca	ause(s) and manner as	s stated. to the cause(s)
the h	Medi	one) 29b. Signature and title of certifier	and manner stated	l.	29c. License	number	2	9d. Date signed (Mont	h, Day, Year)
T S		255.519.111.15	0200	O \cdot	D7	3452		02-01	-2005
		30. Name and address of person wh	o completed cause of deat	h (Item 23a) [Typ			Q: #2	20. 8-	10-M
9		27 41011	M) - ((000	10011	0004070	100	012	~ 1 800	20716
Si Regis	tate trar	31. Date filed (Month, Day, Year) FEB 0 8	2005 32. Reistrar's	Signature	had a				
	4 5		- JOSEPH CONTRACTOR	155					

ORIGINAL

				1- State of Maryland / Department of Hea Certificate of De			ien o () ()	5	03611
_		Physici		Decedent's Name (First, Middle, Last) LAWRENCE CHARLES BLUMENAUER, SR.		2. Date of Deat Month Februar	Day	Year	3. Time of Death 6:50 P M
		/Medio		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loc		repruar.	4c. County	of Death	
		LAdimi		OAK CREST VILLAGE CARE CENTER Parkvill	e		Balti	more	County
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If the Months Days H	Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, Aug 16,	Year)	9. Birthpl	ace (State or Foreign try)
_		Director		216-01-3830 17 M 2 F 91 Yrs. Months Days H		Aug 16,	1913	Mar	yland
ح		pu >		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location				10	Od. Inside City Limits
2		ith the Marylar or 28e-f show	<u>_</u>					1	1 ☐ Yes 2X No
		89-1	Sc	Maryland Baltimore County Parkville					
S)			by Funeral Director	10e. Street and Number 10f. Zip Code 212	234	11	0g. Citizen of W $oxdot{U}_i$	sA	try?
		deal	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Spec Mexican, Puerto F	cify Yes or No-		- America	an Indian,
10	9	within 72 hours after death wene. then "netural", or Items 23e the Medical Examiner rust in	F	1 Never Married 2 Married 1 Yes 2 No	Specify:		Specify.		
3	5-0036	"netural",	d b					VVLI	ite
~	5-	72 P	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done durin life. DO NOT use retired)	n ng most of workin	g	16b. Kind of Bu	siness/Ind	lustry
9	2121	Aithin ne.	id m	Elementary/Secondary (0-12) College (1-4or 5+)				~	٠.
_		be filed v ital Hygie id other t event, IL	ပိ	11th Salesman 17. Father's Name (First, Middle, Last) 18.	. Mother's Name	/First Middle N			pplies
7	Maryland	2 should be filed within and Mental Hygiene. is marked other then eumatic event, tre M.	Be			(not, middle, n			
	Σ̈́	should nd Men marke umatic	ပ္	Charles J. Blumenauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and I	Marie	Route Number	Nast		
V	Z Z	d 2 s th an th an treu treu		Margaret M. Blumenauer (Daughter) 5 Murdock R					·
(3)	ď,	1 an Heal Hem 2	1	20a. Method of Disposition 20b. Place of Disposition (Name of			20c. Location -		
7	0	ages ont of t: If If		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	odba 2/1/	1/200E	Talana a a da a	16-	1
NAC G	Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tre				J1 ZUU)_	TTHOUTU	er, Me	aryrand
7	Ba	Depar Impo any ir		21. Signa urg/ (Funeral Service Vicence 22. Name and Address of Mitchell-Wi	edefe1d	Funeral	l Home,	Inc.	
2				Martin D. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, st shock, or heart failure. List only one cause on each line.	oad Ba	respiratory arr	_{st,} Mary 1a	and 2	Approximate Interval Between
J)_		Physician	П	Immediate Cause (Final					Onset and Death
		/Medical		disease or condition resulting in death) a. Bacterial preumo Due to (or as a consequence of):	7100				
\succeq		Examiner							
3			Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
1	٧	cuted nd ransi	Examiner	that initiated events C.					
3	0	e exe ien al		resulting in death) Last Due to (or as a consequence of):					
	6876	icate be executed physicien and the burial-transit	edicai	d					
1		ing p					1		
\cup	Вох	eath cert attendin for use	lan/	23b. Was decedent pregnant in the past 12 months?			23d. Date Mor	e of delive hth	ry Day Year
		that the death certined by the attending	Physician/M	1 □ Yes 2 □ No 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown					
(1)	P.0	hat th od by detac	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	n Part I.	23e. Did tob	pacco use contr	ibute to th	e cause of death?
7	Records,	w requires that been signed I should be det	d by			1 □ Ye	s 2 No	3 🗌 Prob	ably 4 Honknown
3	Ö	requ been	ete			24a. Was a	24h V	Vora autor	osy findings available
111	360	has has	Completed			autops	y p ned? d	rior to con eath?	npletion of cause of
76		r. Th				1 ☐ Yes 2	2 400 1	Yes	2 No
AWRENC	Vital	Physicien: The law r this certificate has t ral director, page 2 s	o Be	examiner?	 Place of Death Nursing Hom 	2		r /Coogifi	-
\leq	of	g Phy er this eral d	. To			8d. Describe ho			7
J	on	iding Phi th. : After thi funeral	ţ	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes	2 🗆 No				
	Division	Atter r dea sctor by the	Certification;	3 Suicide 4 Homicide 4 Homicide 6 Could not be determined 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify)	2	8f. Location (St City or Town	reet and Number	er or Rura	l Route Number,
	ā	el or s efte	Sert	4 Homicide building, etc. (Specify)		Only of Your	, otato)		
		To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours effer death. To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dicai (date and place, a on, death occurre	nd due to the ca d at the time, d	ause(s) and ma ate and place, a	nner as st ind due to	ated. the cause(s)
		o the ithin (o the ample	Med		ımber	2	9d. Date signed	(Month, I	Day, Year)
		F 3 F 8			646	*		name.	7 1011-
		1		de la completad assessat de colo (france Colo) (Truco Colo)			s proce		2005
		4		Anna Monias 8800 Walther Boulevard	Pa	rkvill.	- W	0 2	1234
		St	ate	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anna Monia's 8800 (Ualther Boulevard) 31. Date filed (Month, Day, Year) FEB 0 8 2005	· · ·				
		Ponist	HOH	TEM U.O. / HIP Wilson					

			1 - For State of Maryland Registrar		artment of Health and Tificate of Death		iene 2005	03612
			Decedent's Name (First, Middle, Last)			2. Date of Dear Month	th	3. Time of Death
	Physici /Medic	al	Montgomery Keene Brown			January		1:30 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea	ith	4c. County of Dea	
	Funeral		1557 Main Street 5. Social Security Number 6. Sex 7. Age (In yrs. las	t birthday)	Whiteford If Under 1 Year If Under 24 Hr		Harfo:	CCI thplace (State or Foreign
	Director		219-58-1243 1×M 20F 5	3 Yrs.	Months Days Hours Mir	Month, Day,		RYLAND
	w.		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	cation			10d. Inside City Limits
	Maryl -f sho	ţŏ	MD Hoford II	Shit	eford			1 □ Yes 2 No
	h the	Director	10e. Street and Number	21111	10f. Zip Code	1	0g. Citizen of What C	ountry?
	23e c	alD	1557 Main Street		21160		USA	
	er de	Funeral	11. Marital Status // NENOW N 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married	13. \	Nas Decedent of Hispanic Origin? (f Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi	
336	urs aft	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes. 2 ☐ No If Yes, Give Year or Dates:	1	I□Yes 212 No Specify:		Specify: U	shite.
21215-0036	filed within 72 hours after death with the Maryland Hygiene ther than Instural; or Items 23e or 28e-f show ont, the Medical Ezan, ar must be indiffed at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decec	dent's Usual Occupation kind of work done during most of w	orking	16b. Kind of Business	/Industry
2	ne. han "	mple	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	OO NOT use retired)	J.Killy	1) 11.	1
	filed v Hygie other t		17. Father's Name (First, Middle, Last)	1016	18. Mother's Na	ame (First, Middle, I	Maiden Surname)	Lumber-
an	lid be lental rked c	To Be	Sanford H. Brown		Paul		Sheler	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene importent: If item 27 is marked other than "natural", or Items 23e or 28e-f show any niuty or other treumatic event, the Medical Examble or must be indiffed at ance.		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Number or F	Rural Route Number	City or Town, State,	Zip Code)
	l and fealth om 27 ther tr		Kenneth P. Brown	0312	2 Prook Arr., sition (Name of		oreMI	
nor	Pages nent of hint: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	netery, cren	natory or other place)		20c. Location - City of	Town, State
altimore,	nit. Plantme orten injury	i	'4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee	S+UL 22	SEAT CHAPET - 2 . Name and Address of Facility 23	25 VARK 1	DIACON	14 MD21092
ä	permit. Departr Importe any nje		Kynberly V. Swrotky	1.0	ACEFUL ALTERNA			
			23a. Part 1. Enter the disease, or complications that caulled the death. shock, or high failure. List only one cause on each line.	Do not ente	er the mode of dying, such as cardi	ac or respiratory arm	est,	Approximate Interval Between
뿔	Physician		Immediate Cause (Final disease or condition resulting in death)	C	arcinoma			Onset and Death
	/Medical Examiner		Due to (or as a consequent	nce of):	- hemator	na-		Liverk .
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	nce of):	_ 1/4/0001	, 0 –		1 00 110
	nd nd transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
8760,	icate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequent	109 of):				
687	ficate physi s the b	edicai	d.					
Box (The law requires that the death certific tle has been signed by the atlending p tage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnance and the big		Description of the second of t		23d. Date of de	livery
.O. B	that the death cer ed by the attendir detached for use	sicia	in the past 12 months? 1		Ectopic pregnancy Other (specify)		Month	Day Year
Ρ.	hat the	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulti	ng in the u	adorhina causa awan in Root I	23e Did tol	pacco use contribute t	o the assume of death?
ds,	uires tha signed Id be dei	d by	Alcohol abuse	ng in the di	identifing cause given in Fait i.	1 □ Ye		robably 4 Unknown
Vital Records,	s been s should	ompleted				24a. Was a	n 24b. Were a	utopsy findings available
Re	The lav	mo				autops perform	ned? prior to death?	completion of cause of
/ita		BeC	25. Was case referred to medical examiner?		26. Place of De	ath Check onl on	1-	
of o	Phys this al dii	5 T	1 ☐ Yes 2 Tho Hospital: 1 ☐ Inpatient 2 ☐ EF	VOutpatien		-	ence 6 Other (Spe	icify)
on	Jing After fune	tion	1 Matural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	8b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	280. Describe no	w injury occurred	
Division	l or Attending after death. Director: Afte in by the fune	ertification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office	28f. Location (St City or Town	reet and Number or F	ural Route Number,
Ö	itel or A irs after ret Direc led in by	0						
	Hosp 24 hou Fune rtely fii	edical	29a. Certifier 1 Certifying Physicien: To the best of my knowle (Check only one) Medical Exeminer: On the basis of examination and manner stated	n and/or inv	restidation, in my opinion, death occ	curred at the time, di	ate and place, and du	s stated. e to the cause(s)
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Mec	one) and manner stated. 29b. Signature and title of certifier		29c. License number	2	9d. Date signed (Mon	
•	/ //	1	· mary Elaigh		D005457	3	2/1/	05
(1		and manner stated. 29b. Signature and title of certifier Way E Caip M 30. Name and address of person who completed cause of leath (Item 2 May E. Chaip M 1718 V 31. Date filed Month, Day 7447) 18 20012. Regist 1: Signature	За) (Туре,	Print) Print) Od	Towest	Kinllo LA	02/084
	<i>y</i> '		31 Date filed Month Day (Flat) 1. 0 and Panisher's Singer	U. Ja	NIEUSUIUS ROL	1		
	Sta Registr	te ar	FEB 0 0 2005	J.	your			

				State of Maryland / Department State of Maryland / Department Certification	nt of Health and M te of Death		giene 0 0	5 (03613
				Decedent's Name (First, Middle, Last)		2. Date of Dea	th 1		3. Time of Death
		Physici /Medic		Clara Elizabeth Berta	mini	F& Brn.	Day 376	Con	9:45P M
		Examir		4a. Facility Name (If not institution, give street and number) 4b. City	, Town, or Location of Death		4c. County of	Death	
				North Arundel Hospital Gl	len Burnie		Anne A	Arun	del
		Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Months 21220-5935	or 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day Sept.	Year) 4 . 1923	Count	ace (State or Foreign try) vland
		pu ,		Usual Residence of Decedent					
		aryla	_	10a. State 10b. County 10c. City, Town or Location				10	Od. Inside City Limits
		death with the Maryland ms 23a or 28e-f show Livust be notified at	Director	Maryland Anne Arundel Pasadena					1 ☐ Yes 2 🔀 No
		with t	Dir	10e. Street and Number 10f. Zi	ip Code	1	0g. Citizen of Wh	at Count	try?
		s 23	rai	1449 Tar Point Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dece	21122	-7 M	U.S		
		ter de Item	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. If Yes, spe	edent of Hispanic Origin? (Spo ecify Cuban, Mexican, Puerto	Rican, etc.)		White, e	
	36	irs af	by F	3 ☐ Widowed 4 ☑ Divorced Year or Dates:	2 No Specify:		Specify:	Whi	to
	ŏ	2 hou	ted	15. Decedent's Education 16a. Decedent's Usu	ual Occupation		16b. Kind of Busi		
	215	hin 7	Completed	(Specify only highest grade completed) (Give kind of w Elementary/Secondary (0-12) College (1-4or 5+)	ork done during most of work use retired)	ing			
	21	ed wit	No.	8 N/A Machini	ist		Manufact	urin	g Company
	pu	al Hy al Hy doth	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, i	Maiden Sumame)		
	<u>ya</u>	2 should be filed within 72 hours after and Mental Hygiene. Is marked other then "naturel", or Ite eumetic event, It e Model Examina	10 E	John Peter Cavanaugh	Florence]	Katherin	е	Funk
	Maryland 21215-0036	12 sho h and 7 is m treum		1000	s (Street and Number or Rura				
		permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-f show eny injury or other treumetic event, the Modical Examiner must be multified at once.	1	Andrew M. Bertamini (Son) 1449 Tar 20a. Method of Disposition 20b. Place of Disposition (Na cometery, crematory or	Point Road P	The state of the s	, Mary Lai 20c. Location - Ci		
	altimore,	Pages ent of nt: If i		1 ■ Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Cedar Hill Ce		05 1	Brooklyn	Mare	ul and
	a E	mit. partm partm sorte / inju		21 Signature of Funeral Service Licensee	nd Address of Esciliby				утана
9	m	Depar Depar Impos eny ir			lly-Polyniak F Mountain Road			and :	21122
U	П			23a. Pant Enter the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on each line.	de of dying, such as cardiac o	or respiratory arre	est,		Approximate Interval Between Onset and Death
4		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	N/ Inta	rutis	M		Onset and Death
		Examiner		Due to (or as a consequence of):	ic Patro	1 Fa	Vw 8		
4	-	D H	iner	Enquentially flet enrollions, if any, leading to immediate cause. Enter Undertying) 0	(0)	, ,		
2	1	cate be executed physician and the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or a la consequence of):	per to	J 81,20	<u> </u>	-	
3	8760,	be exician buria		556 10 (01 d d d d d d d d d d d d d d d d d d d	3				
7	58	ficate physics the	edicai	d					
2	1	death certifi e attending d for use as	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of	of deliver	v.
7	m	leath atter	ciar	in the past 12 months?			Month	•	y Day Year
0	6	that the death certifiined by the attending to detached for use as	Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown					
N	S, P	res that the d igned by the be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	23e. Did tob	acco use contribu	ute to the	cause of death?
,	ğ	w requires been sign should be				1 □ Ye	s 2 No 3	☐ Probal	bly 4 🗍 Unknown
-	ecord	law as b	Completed			24a. Was ar autops	n 24b. We	re autops	sy findings available pletion of cause of
~	α	ysicien: The law is certificate has b director, page 2 sl	mo.			perforn	ned? dea	th? Yes 2	
3	Vital	sien: artific ctor,	Be (25. Was case referred to medical examiner?	26. Place of Death		10		1
_	of V	S D	2	1 Yes 2 No Hospital: 1 Appatient 2 EP/Outpatient 3 Do	OA Other: 4 Nursing Hor	ne 5 🗆 Reside	ence 6 Other	(Specify)	
1)		ding Phys	on:	f Natural 5 Pending (Month, Day Year) Injury	Work?	28d. Describe ho	w injury occurred		
	sio	Attending r death. ector: After by the fune	cati	2 Accident investigation M	1 ☐ Yes 2 ☐ No				
	Division	or At after of Direct in by	Certification:	determined determined determined determined determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	ry, office	28f. Location (St. City or Town	reet and Number (n, State)	or Rurai i	Route Number,
	J	spitel nerel filled		29a. Certifier **Tertifying Physician: To the best of my knowledge, death occurred	at the time, date and place a	and due to the ca	luse(s) and mann	er as stat	ted.
		To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	n, in my opinion, death occurre	ed at the time, da	ate and place, and	due to t	he cause(s)
		To t To tl com	M	29b. Signature and title of certifier	c. License number	29	9d. Date signed (#	Month, D	ay, Year)
) TO TO	14800		C/4/	20	05
		4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Jr., 65	en B	mnit,	m) Z1061
		Sta		31. Date filed (Month Day Year) 2005 33 Segistrar's Signature	,				
		Registr	ar						

State of Maryland / Department of Health and Mental Hygier 0 5 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** Year Feb. 11:05 PM Norma Sophia Breznicky 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Sept. 15 1922 Gilchrist Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1□ M 2 F Director PÃ 82 182-16-0588 Usual Residence of Decedent with the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28a-f show other traumatic event, the Modical Examinar must be notified at MD Baltimore Parkville Director 1 Yes X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7706 1/2 Queen Anne Dr. 21234 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: white 1 ☐ Yes 2 X No Specify 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 73 h and Mental Hygiene. 7 Is marked other than "ni Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Raymond Steven Van Blargan Sophia Gudalewsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 Is
any injury or other trac Jerry Breznicky/Son 18233 Falls Rd., Hampstead, MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 2/8/05 1

Burial 2 □ Cremation 3 □ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD Lemmon Funeral Home of Dulaney Valley 10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Furteral Service Lic owell M. Faith Enter the tip ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tiple **Physician** MUL m ars /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Pyes 2 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier , mil 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11 Cho Some 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar FER 0 8 2005

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760

Sreenicky, Norma grink /4/05/211:05

DHMH 17 Rev 1/2001

BAKER, SAMES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Stete Registrer	State of Maryland		of Health and of Death	Menta	al Hygien	UUJ	03616
I	Physici /Medio		1. Decedent's Name (First, Middle, La	1 (1) (1)			Mo	ite of Death onth E	Day Yeer	3. Time of Death 7:35 AM
	Examir Funeral	er	4a. Facility Name (If not institution, gives 1) 100 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	TAL OF BAL	Timaze 9		012E	C ITY	4c. County of Dea	th NA
	Director		917 - 01 - 1435 Usual Residence of Decedent	M 20 F 42	Yrs. Months	Days Hours Mi	n. 12	onth, Day, Yea - 21-1	2	ountry) MB
	death with the Maryland ms 23e or 28e-f show	ector	10a. State 10b. County	NA 10c. City, To	own or Location	utimore		· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits
	sath with I	Funeral Director	3413 Dennlyn	Riad	10f. Zip	21215			Citizen of What C	Į į
9800	be liled within 72 hours after death with the Marylan lat Hygiene. Ital Hygiene. d other than "naturel", or frems 23e or 28e-f show event, the Madical Examinator must be nutilised at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Amed Forces? 1Yes 2No If Yes, Give Year or Dates:	13. Was Deceded If Yes, spec	ent of Hispanic Origin? ify Cuban, Mexican, Pue	(Specify Yearto Rican,	es or No- etc.)	14. Race - Am Black, Whi	
21215-0036	od within 72 hours after gjene. er than "naturel", or Ite i Itiu Medical Exandra	Completed	15. Decedent's Ed (Specify only highest gra		life. OO NOT us	k done during most of w	orking	16b.	Kind of Business Western	Vindustry I Electric
_	Men Men arke	To Be (17 Father's Name (First, Middle, Last)	ker '		bess	ie 1	Middle, Maide		
	s 1 and 2 sho f Health and item 27 le m other treum		19a Informant's Name/Relationship (3	3413 Deni	(Street and Number or I	Ba	ltimore	mo	21215
	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Donation 5 ☐ Other (Specification)	Removal from State	of Disposition (Name of Property) or other of the control of the c	her place)	Date	5 Ba	Himore	MD
Ba	permit. Pag Depertment. Importent: It any Injury o		21. Signature of Funeral Service Licer		8728 L	Address of Facility of	1. Ra	ndalla	our fun	ual 8nic. 10 21133
	The death certificate be executed The attending physicien and the attending physicien at the principle of the attending physicien at the attending physicien and attending physicien at the attending physicien attending phys	dical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence. Due to (or as a consequence. Due to (or as a consequence.	ce of):	leart al fai	Fa	شاك	re	Approximate Interval Between Onset and Death) Lars Lars
O. BOX 6	ath certification or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnancy Live birth 2 Fetal dea Pregnant at time of death 9 Unknown	ath 3 Ectopic pre				23d. Date of de Month	livery Day Year
ds, P.	ures that the de signed by the a Id be detached f	by	Part II. Other significant conditions of	ontributing to death but not resulting	g in the underlying ca	use given in Part I.	23	Be. Did tobacco		o the cause of death?
Hecords,	ine law requires mat ate has been signed b page 2 should be deta	Completed						a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
VII	yelclen; In	Be	25. Was case referred to medical examiner?	Hospital:		26. Place of De				
lon or	aing Pnye h. After this funeral dii	ation; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		c. Injury at Work? 1 Yes 2 No		Residence	6 □Other (Spe ury occurred	cify)
DIVISION	s after deserted by the best of the bird of the best o	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury · At home, building, etc. (Specify)	, farm, street, factory,	office	28f. Loc City	cation (Street a y or Town, Sta	and Number or Ri te)	ural Route Number,
	To the Hospital of Attentivition 24 hours after deatl To the Funeral Director: completely filled in by the	edicai	one)	ysician: To the best of my knowled iner: On the basis of examination a and manner stated.	and/or investigation,	in my opinion, death occ	e, and due curred at th	e to the cause(: le time, date ar	s) and manner as nd place, and due	s stated. to the cause(s)
,	To To Com	Σ	29b. Signature and title of certifier	. 0		License number			ate signed (Mont	
	./		30. Name and address of person who	completed cause of death (Item 23a		RES ODS		FEE	BRUAR	14,2005
	15		LOMAL LAWE 31. Date filed (Month, Day, Year)	DCE MD 240	723 VV 10	BELVES	TERE	Ba	ILTIMO	4,2005 2E MD21215
	Sta Registr		FEB 0 8 2	32. Redistrar's Signature	: Sparke	,				

DHMH 17 Rev 1/2001

Barbiere, Domenick Baltimore, Maryland 21215-0036

			For Stata	State of M	<i>l</i> aryland	l / Depa م	artment of F rtificate of	lealth an Death	nd Mental			03617
			Registrar 1. Decedent's Name (First, Mid	ddle, Last)			runcate or	Dealli	2. Date o	Rag. N		3. Time of Death
	Physici /Medic		Domenick John	Barbiere					1 Month	Vary	ay 03 Year	- 125× M
	Examin		4a. Facility Name (If not institut		r)		4b. City, Town, o	r Location of E			c. County of Death	1
	*		Stella Maris a					Baltimo		В	altimore	city
	Funeral		5. Social Security Number	6. Sex 7. A	Age (In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours			9 Birth	nplace (State or Foreign untry)
•	Director		110-18-8019 Usual Residence of Decedent		80	113.			08/	10/19	24 NY	
	laryland show		10a. State 10b. Coun		10c. City,	Town or Lo	ocation					10d. Inside City Limits
	Mar Ba-fsh	ctor	MD Balt	timore	Luth	ervil	lle Timon	ium				1 □ Yes 2 No
	th the	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Cou	untry?
	ath w	rai	2304 Eastlake				21093			USA	A	
	er de	Funeral	11. Marital Status	12. Was Deceden Armed Forces	32	. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin an, Mexican, P	? (Specify Yes o uerto Rican, etc.	r No-	 Race - Amer Black, White 	
36	rs aft	by F	1 ☐ Never Married 2 ☐ M 3 ☑ Widowed 4 ☐ Divorce	If Voc Cino			1 ☐ Yes 2 No	Specify:			Specify:	
21215-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show dical Examination in chiffed at	ted	15. Deced	dent's Education	·	16a. Dece	dent's Usual Occup	ation		16b. I	Whi Kind of Business/li	
215	within 7, ene. than "n he Medi	Completed	(Specify only high Elementary/Secondary (0-12	thest grade completed) 2) College (1-4or	r 5+)	(Give life.	kind of work done DO NOT use retired	during most of d)	f working		stinghous	•
	ed wit	Con			+	Elect	rical En	gineer				
pul	12 should be filed within h and Mental Hygiene. 7 Is marked other than " traumatic avent, the Mes	Be	17. Father's Name (First, Middl	le, Last)				18. Mother's	Name (First, Mid	ddle, Maide	n Surname)	
<u>Y</u>	Men Men Marke Matic	ဥ		rbiere					arie Moz			
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Maryla it of Health and Mental Hygiene. If item 27 is marked other than "natural", or itams 23a or 28a-f shoy or other traumatic avent, the Medical Examinational to indiffed at		19a. Informant's Name/Relatio Beth Roberston				ng Address (Street			-		
	Health Health tem 27	1	20a. Method of Disposition	Daugnter	20b. Pla	ce of Dispo	E Clement		t Baltın		MD 21230 ocation - City or T	
JOH.	Pages nent of t			on 3 Removal from State	Θ	-	natory or other plac	1	Feb 5			
Baltimore,	2 2 2 2		21. Signature of Funeral Service			-	ke Cremat 2. Name and Addre		c. 2005	Bel	tsville,	Maryland
m	Departing Department of the poores.		1 Start	all	120 081		remation					ryland 21286
F.			23a. Part1. Enter the disease, shock, or heart failure. L	or complications that cause ist only one cause on each	ed the death.	Do not ent	er the mode of dyin	g, such as car	rdiac or respirato	ry arrest,	Imore, Ma	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		CI	ch	cico					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a conseque		<u> </u>					
	LAMITIME	_	Sequentially list conditions,	b								
$\sqrt{}$	ted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conseque	ence or):						
	al-trai	xar	that initiated events resulting in death) Last	c Due to (or a	s a conseque	nce of):						
68760,	ificate be executed g physician and as the burial-transit	edical		d								
-	= O 6											
Вох	death certi e attending ed for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pregnancy	,			23d. Date of deliv	,
0	0 0	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant : 9□ Unknown			Other (specify)				Month	Day Year
σ.	The law requires that the de ate has been signed by the a page 2 should be detached		Part II. Other significant condi	litions contributing to death	but not result	ing in the w	nderlying cause and	on in Part I	230 [Oid tobacco	use contribute to t	the cause of death?
ds,	uires tha signed Id be de	d by	Tarring of the control of the contro	The contributing to doubt	Dat Hot rosalt	ing in the th	idenying cause givi	on in Fait i.			_ /	bably 4 □Unknown
Ö	w requ	lete			-				-	Vas an		
Vital Record	The tav	Completed							— a	utopsy erformed3	prior to co	opsy findings available ompletion of cause of
tal		a	25. Was case referred to medic	ical				26 Place of	1 ☐ Ye Death (Check or		1 ☐ Yes	2 No
Ξ	Q 0 0	To B	examiner? 1 ☐ Yes 2 🗹 No	Hospital:	ient 2 🗆 Ef	P/Outpatien	t 3 DOA Othe	or	ng Home 5 - F		6 Other (Speci	Masoice
u of	ding Ph h. After th funeral		27. Manner of Death 1. Natural 5 □ Pend	28a. Date of Inj (Month, D	jury 2 av Year) 2	8b. Time of	28c. Injun Worl				iry occurred	" Nospice
siol	endir eath. or: Al	catio	2 Accident inves	stigation		,,		Yes 2 □ No				
Division	al or Attendin s after death. I Director: Af d in by the fur	Certification:		armined 286. Place of It	njury - At hom etc. <i>(Specify)</i>	e, farm, str	eet, factory, office		28f. Location City or	n (Street al Town, State	nd Number or Run e)	al Route Number,
	pital ours a eral [29a. Certifier 1 Certify	ying Physician: To the bes	t of my knowl	adaa daath	and the single	- dota and al	lane and durab			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	(Check only 2 Medica	cal Examiner: On the basis and manner s	of examinatio	n and/or inv	estigation, in my o	pinion, death o	occurred at the tir	ne, date an	d place, and due to	tated. o the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of cert	tier			29c. License	e number		29d. Da	ite signed (Month,	Day, Year)
)			> DM 1	() -			DH	0854		21	3/200	5
	10		30. Name and address of person	on who correleted cause of	death (Item 2	3a) (Type,						
	10			scherg 301	ST	Pau	I PLE	Baltir	none	nd.	2120	2
	Sta Registr		31. Date filed (Month, Day, Yea		rar's Signatui	re A.a	1					
	- negisti	CII	FEB	0 8 2005	63.45	1.	anare)					

			1 - State Registrer	State of Maryland / Dep	partment of He			ene .2.005	03618
			Decedent's Name (First, Middle, La				2. Date of Death Month	Day Year	3. Time of Death
	Physici: /Medic		DOROTHY	BARTENFELDER			JAN	28 2009	
	Examin	er	4a. Fecility Name (If not institution, giv	e street and number)	4b. City, Town, or L	ocation of Death	, MD	4c. County of Death BALTIMON	
	Funeral Director		5. Social Security Number 6. S	ex 7. Age (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, Y	ear) 9. Birth Con	nplace (State or Foreign Intry) FYLAND
	and		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or	Location				10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show criust be riutffled ut	tor	MARYLAND BALTII	MORE BALT	IMORE				1 ZYes 2 □ No
	vith the	Funeral Director	10e. Street and Number		10f. Zip Code	- *	10g	J. Citizen of What Cou	untry?
	ns 23e	eral	401 OLD HOME 1		3. Was Decedent of His	panic Origin? (Spec	ify Yes or No-	U. S. A. 14. Race - Amer	ican Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if the Marylan teams 23a or 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic evant. The Medical Examiner must be rutilized at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1	If Yes, specify Cuban, 1 ☐ Yes 2 🕱 No	Mexican, Puerto R Specify:	ican, etc.)	Specify:	
5-0036	72 hou natura	eted	15. Decedent's E (Specify only highest gra	ade completed) (Gi	cedent's Usual Occupative kind of work done du			6b. Kind of Business/I	
121	within iene. than "	Completed	Elementary/Secondary (0-12)	Callaga (4.45 5.)	DO NOT use retired) AIMS EX			TATE OF	MARYLAND
land 2	be filed ta! Hygi d other evant.	Be C	17. Father's Name (First, Middle, Last			8. Mother's Name		uiden Surname)	
ryla	d Ment d Ment marke matic e	2	FREDERICK 19a. Informant's Name/Relationship (OYERMAN Type Print! 19h Ma	iling Address (Street ar	MARY EL	IZABE	TH SEL	B Y
Mary	alth and 27 is m		DENISE WHITMA		42 FOUNT	AIN ST.	BALTIN	HORE MA	RYLAND
ore,	iges 1 a nt of He ff item or othe		20a. Method of Disposition 1 ☐ Burial 2 🖫 Cremation 3 ☐	Removal from State cemetery, ci	rematory or other place,	,			
altimore	t. Partmer		*4 ☐ Donation *5 ☐ Other (Special 21. Signature of Funeral Service Lice)	(v) BAYVIE	22. Name and Address	RY FEBRUA	Ry 4 2005	BALTO, I	MARILAND
Ba	Department of the partment of) Catherine	- M. Zeelas	1901 EAS	TERN AL	E. BAL	TIMORE, N	10 21231
			23a. Part1. Enter the disease, or com shock, or heert failure. List only Immediate Cause (Final		enter the mode of dying,				Approximate Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	a C.diff coh' Due to (or as a consequence of):	<i>h</i>				Jan.
	Examiner	L	Sequentially list conditions,	b. Sheptococco	l bacte	rencia	`		anys
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	thrombosi's	of fernor	al arte	ries		Lays
60,	be executed ician and burial-transit		resulting in death) Last	b. Shepto cocce Due to (or as a consequence of): thrombosis Due to (or as a consequence of): thrombosis Authorities Renal for	luce				years
68760	phys the	edical		d	cu u C				0
Вох	eath certific attending p	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of deliver Month	very Day Year
O.	that the death ed by the atte detached for	hysic	1 ☐ Yes 2 🗗 No 9 ☐ Unknown	9□ Unknown	oli ottiei (specily)				
rds, P	es be		Part II. Other significant conditions	contributing to death but not resulting in the	underlying cause giver	in Part I.		cco use contribute to 2 No 3 □ Pro	the cause of death?
Vital Records,	has b	Completed					24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
ta		a)	25. Was case referred to medical			26. Place of Death			2 No
of Vi	dis d	To B	examiner? 1 Yes 2 No	Hospital: 1.2 Inpatient 2 ER/Outpat		4 Nulsing Hom		ce 6 □Other (Spec	ify)
ou o	fter ne	tlon:	27. Manner of Death 1→Natural 5 Pending 2 Accident investigatio	28a. Date of Injury 28b. Time (Month, Day Year) Injury	/ Work?	at 28 as 2 □No	3d. Describe how	injury occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigatio 3 Suicide 6 Could not be determined	DB CO. Place of Injury At home form			3f. Location (Stree City or Town,	et and Number or Ru State)	ral Route Number,
	pital o		29a. Certifier 1 🗷 Certifying Pl	hysician: To the best of my knowledge, de		date and place as	3d due to the cou	55(a) and manner 00	stated
	n 24 hc	Medical		miner: On the basis of examination and/or and manner stated.					
	To the To the Comp	Σ	29b. Signature and title of certifier	ald MAN	29c. License 3 3			Date signed (Month	
•	6		30. Name and address of person who	7		1709		128/05	
	ソ		J	ивмС 4940 EAS		UE, BALT	IMORE,	MARYLAND	21224
	Sta Regist		31. Date filed (Month, Pay, Year)	32. Registrar's Signature	Posette 1				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State of Maryla	and / Depa	artment rtificate	of H	ealth a	and M		giene Reg. No.	05	03619
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last) HARLY EDNIE BLAIR						2. Date of De Month	Day 4	Year 2005	04 60
	Examir	ner		rs. last birthday)	West If Under	mins Year	If Under:	24 Hrs.	8. Date of Bir (Month, Da	Ca	ounty of Deat	
	Director		107-16-7222	Yrs.		Days	Hours	Min.	Jan 6	1920		hplace (State or Foreign untry) tland
	the Maryla 28a-f shov	ector		City, Town or Lo		Codo			-	10- Cisi		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3a or	Dir	6407 Glasgow Circle			784				USA	n of What Co	untry?
9003	72 hours after death with the Maryland "nature!", or items 23a or 28a-f show idical Ezammer must be nedilled at	ed by Funeral Director		/II & '	1 ☐ Yes 2	No X	Specify:	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)	- 14 S _i	Race - Ame Black, White pecify: Wh	ite
Maryland 21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) +7	(Give	dent's Usual kind of work DO NOT use Cipal	done d retired)	tion uring most	of workir	ng		of Business/	Industry
yland	e d la b	To Be	17. Father's Name (First, Middle, Last) John Blair				Jar	net E	(First, Middle, Brand			
e, Mar	ges 1 and 2 should it of Health and Mer if tiem 27 is marke or other treumatic		19a. Informant's Name/Relationship (Type, Print) Ruth Mason (daughter)	6407	Glasgo	ow C	ircle	, Sy	kesvil	le, M	d 2178	4
Baltimore,	permit. Pages: Department of the importent: if ite eny injury or ot once.		'4 Donation 5 Other (Specify)	Place of Dispo cemetery, cren ringfie	1d Cer	nete	ry 2	2-7-0		Sykes	ville,	Md
■ Bal	permi Depa impo eny ii		21. Signature of Funeral Service Licensee Pargeranght Jerbert	Ρ.	U. Box	19	5 Syk	esvi	lle, Mo	<u>d 2</u> 178	Home & 34	Chape1
8760, <	Provided American and American and American and Ithe burial-transit	ai Examiner	23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of the death of t	structive aquence of): Le Hypological description of the control	5200 Z		Diseo		respiratory ar	rest,		Approximate Interval Between Onset and Death > / YR > / YR
.O. Box 687	death certifii e attending p ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown 1 □ Vas 2 Mo 9 □ Unknown	tal death 3	Ectopic pred					23d	I. Date of delive Month	very Day Year
٥	es pe	by	Part II. Other significant conditions contributing to death but not re	esulting in the un	nderlying cau	ısə givər	n in Part I.					the cause of death?
Vital Records,	The ate h page	Completed						<u> </u>	24a. Was autop	med?	4b. Were aut prior to co death? 1 \(\subseteq Yes	opsy findings available ompletion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be c	25. Was case referred to medical examiner? Hospital:						Check on o			
of	Attending Physic death. setor: After this by the funeral di	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident 1 Month, Day Year)	28b. Time of Injury		: Injury a Work?	4 □ Nur at es 2 □ N	28	e 5 Resid			fy)
Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined building).	home, farm, stre	eet, factory,	office		28	Bf. Location (S City or Tow	itreet and N n, State)	umber or Rur	al Route Number,
	To the Hospitel or A within 24 hours after To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my king 2 Medical Exeminer: On the basis of examination and manner stated.	nowledge, death nation and/or inv	occurred at estigation, in	the time my opi	, date and nion, death	place, ar occurre	nd due to the d d at the time, d	ause(s) and date and pla	d manner as s ace, and due t	stated. o the cause(s)
ŧ	To To com	Σ	29b. Signature and title of certifier			icense 208				29d. Date si	gned (Month,	Day, Year)
	8			BORTY R	Print)	ELL)cRSBC	126	MO Z	1784		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Sig	A A	in the							

			For State Registrar	State of Maryland		artment of F		nd Mental H	- /	2005	03620
			Decedent's Name (First, Middle, Last	it)			2001	2. Date of D			3. Time of Death
	Physici /Medio		RALPH BEDI	ELL, JR.				Month Feb	Da	Zoo5	17:19 PM
	Examir		4a. Facility Name (If not institution, give	· ·		4b. City, Town, o	or Location of D	Death	40	County of Deat	1
		٠	HOWARD COUNTY	HOSPITAL	- h = - h	If Under 1 Year	It Under 24			Howa	
	Funeral Director		5. Social Security Number 6. S 424-42-85-16		8 Yrs.	Months Days		Min. 8. Date of B	ay, Year	9. Bin	thplace (State or Foreign
	D		Usual Residence of Decedent					020		7	,,
	Aaryla I shov	ō	10a. State 10b. County Howai	4	Town or Lo	mbia					10d. Inside City Limits 1 ☐ Yes 2 ☑No
	286-	Director	10e. Street and Number		COIVE	10f. Zip Code			10a. Ci	tizen of What Co	
	72 hours after death with the Maryland natural', or Items 23a or 28e-f show dical Exama or most be motified at	al D	9277 Soaring Hill	Road		210	45			USA	
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13.	Was Decedent of h	Hispanic Origin an, Mexican, P	? (Specify Yes or Note of Rican, etc.)	lo-	14. Race - Ame Black, White	
36	rs afte	by F	1 Never Married 2 2 Married 3 Widowed 4 Divorced	1 MaYes 2 □ No If Yes, Give Year or Dates:		1⊡Yes 2⊠XNo	Specify:				ack.
21215-0036	2 hou		15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occur	pation		16b. K	(ind of Business/	
21	ithin 7 ne. han "r	Completed	(Specify only highest gra	College (1-4or 5+)	life.	kind of work done DO NOT use retire	d)	working	TO	Jeldina	Sundia
121	filed within Hygiene. thar than "		1211 grade 17. Father's Name (First, Middle, Last)	N/A	Utilit	y/Quali		Name (First, Middle		uilding	ageng
Maryland	ld be ental kad o	To Be	Ralph Bedeil Sv	4			Mart	ha Edwa		i Sumame) —	
ary	2 should be and Mental is marked o	_	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	g Address (Street	and Number o	r Rural Route Numi		or Town, State, 2	Zip Code)
	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If itam 27 is marked other than "natural", or Items 23s or 28e-f show or other traumatic event, the Medical Exam arms Le multibute.		Helga Bedell / Wil	<u> </u>	4277	20011	fill Koa			MD 2104	15
Baltimore,	Pages 1 nent of H int: If its iry or ot		20a. Mèthod of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	netery, crem	sition (Name di natory or other place	ce)	Date 2:08:05	A	ocation - City or	1
altin	permit. Pages Department of Important: If i any injury or once.		4 □ Donation 5 □ Other (Specify21. Signature of Funeral Service Licen				1 -			nonsvil	KINU
ä	Per		12 ang (4-	S	31 Baitin	ovecné Na	Puneral Se Tunal Pik	e Ba	HO MO 2	1229
			23a. Part1. Enter the disease, or composhock, or heart failure. List only	one cause on each line.	Do not ent	er the mode of dyir	ng, such as car	diac or respiratory			Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Atherosderol		rdicuasa	ular Di	seave			Onset and Death
В	Examiner			Due to (or as a conseque	nce of):						
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury	b. Due to (or as a conseque	nce of):						
V.	xecute and Il-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseque	nce of):						
8760,	cate be executed physician and the burial-transit	dical E		d.=							
9	ph ca	Medi	IF FEMALE:								
Вох	death certifi e attending I id for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnance 1 Live birth 2 ☐ Fetal d	eath 3	Ectopic pregnancy	,			23d. Date of deli	very Day Year
<u>o</u> .	0 0 0	Physician/Me	1 Yes 2 No	4□Pregnant at time of dea 9□Unknown	th 5∟	Other (specify) _				19101111	ouy real
S, P	requires that the een signed by th hould be detache	by Pr	Part II. Other significant conditions co	entributing to death but not resulti	ing in the ur	iderlying cause giv	en in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
ords	w require been sig should b							1 🕞	Yes 2	□No 3□Pro	obably 4 Unknown
Record	aw as b	ompleted						24a. Was	psy	24b. Were aut	topsy findings available ompletion of cause of
alB	Thate are	O						perf	ormed? 2 1 No	death?	2 1 No
Vital		o Be	25. Was case referred to medical examiner? 1 ☑ es 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☑ EF	R/Outpatien	2CI DOA Oth		Death (Check only			15
o C		-	27. Mann of Death		8b. Time of Injury	28c. Injun	y at	ng Home 5 Res 28d. Describe			erty)
sioi	Attanding ir death. ector: Aftei by the fune	catic	1 Satural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1	Yes 2 □ No				
-	after deat Director:	ertification;	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (City or To			ral Route Number,
	To tha Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	0	29a. Certifier 1 Certifying Phy	sician: To the best of my knowle	edge, death	occurred at the tin	ne, date and pl	ace, and due to the	cause(s)	and manner as	stated.
	To tha Ho within 24 To the Fu completel	ledical	ona) 2[Edwiddical Exam	iner: On the basis of examination and manner stated.	n and/or inv	estigation, in my o	pinion, death o	ccurred at the time,	date and	d place, and due	to the cause(s)
	or To Con	₹	e9b. Signature and little of certifier	Depui	5	29c. Licens	e number			te signed (Month	
•			30. Name and address of person who	ompleted cause of death (Item 2	3a) (Type !	Print)	14)	3	te	b 3, 2	005
	13					oche Cone	Way	Ellicot	aty	MD 2	1842
	Sta	•	31. Date filod (Month, Day, Year) FEB 8 2005	Registrar's Signatur		M.			- +		
	Registr	ar	red & 2000	ARRIVED AR	A CONTRACTOR OF THE PARTY OF TH	The state of the s					

			1 - For State Registrar	State of Ma		ertificate of L		lental Hygie Reg.	211115	03621
	Dhusisi		Decedent's Name (First, Middle,	Last)				2. Date of Death Month	Day Yeer	3. Time of Death
ı	Physici /Medic	al	Barbara 4a. Facility Name (If not institution,	Bauman		4b. City, Town, or	Leasting of Death	Feb. 4, 2	2005 4c. County of Deat	12:21 A ^M
	Examin	er	7 Ivy Hill Co				keysville		Baltir	
	Funeral		5. Social Security Number		(In yrs. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birt	hplace (State or Foreign untry)
ļ,	Director		218-26-9643 Usual Residence of Decedent	1 M 2A F	78 Yrs.			Mar. 18,	1926 E	ngland
	yland		10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	8a-f e	Director		timore	Co	ockeysvill	e			1 ☐ Yes 2 No
	with the or 2	Dire	10e. Street and Number 7 Ivy Hill Co	a+		10f. Zip Code	030	10g.	Citizen of What Co USA	untry?
	ms 23	Funerai	11. Marital Status	12. Was Decedent E	Ever in U.S. 13	. Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Race - Ame	
36	hin 72 hours after deeth with the Maryland B. Medical Evandration 23s or 28s-febow Medical Evandration must be notified at	by Fur	1 ☐ Never Mamed 2 ☐ Marrie 3 ☐XWidowed 4 ☐ Divorced	Armed Forces? 1 Yes 2XX If Yes, Give Year or Dates:		1 ☐ Yes 20XNo	Specify:	Rican, etc.)	Black, White	White
215-0036	72 ho	Completed	15. Decedent'. (Specify only highest	s Education grade completed)	(Giv	edent's Usual Occupa e kind of work done of	luring most of worki	ing 16t	. Kind of Business/	
	within iene. than	mpi	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retired, Realt)		Real Es	tate
מ	Hyg thei	Be Co	17. Father's Name (First, Middle, L	ast)		Realt		e (First, Middle, Mai		ta te
Maryland 2	of the po	To B	John H. L. M	logg			Joa	nna Ford		
Mar	O1 07 09 25		19a. Informant's Name/Relationsh			ling Address (Street a				
	ss 1 and 2 of Health item 27 i		Mr. Neil A. Baun 20a. Method of Disposition	ian/son	20b. Place of Disp	Ivy Hill position (Name of		ckeysville	Location - City or	
altimore,			1 ☐ Burial XX Cremation `4 ☐ Donation 5 ☐ Other (Sp			ematory or other place Service Co	1)5 Tow	son, Mary	/land
Balt	permit. Page Department of important: if any injury or once.		21. Signature of Funeral Service L	icenses / Day - S		22. Name and Addres			Funeral I	Home, Inc.
П			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that caused						Approximate Interval Between
,	Priysician	ia i	Immediate Cause (Final disease or condition	-a Resi	MARM	failure				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or V)	a consequence of):	n disease	,			
	4,	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequence of):	Miney	_			
,	acuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
δÜ,	ficate be executed g physician and ss the burial-transit		resulting in death) Last	Due to (or as a	a consequence of):					
09/89	- CD cd	edicai		d						
XOR	The law requires that the death certif te has been signed by the attending tage 2 should be detached for use a.	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		☐Ectopic pregnancy			23d. Date of deli	
	the att	ysici	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at 9□Unknown		Other (specify)			Month	Day Year
ב.	s that the	by Ph	Part II. Other significant condition				on in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Vital Records,	w requires been sign should be		-Yon	o Tempora	Laemen	PIL		1 🗆 Yes	2 No 3 Pro	obably 4 Unknown
ecc	law re nas be	Completed						24a. Was an autopsy	. prior to d	topsy findings available ompletion of cause of
<u></u>								performed 1 ☐ Yes 2 🔽		2 No
	ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2 ER/Outpation	ent 3 DOA Othe	No.	me 5 Residence	e 6 □Other (Spec	ify)
n of	ng Ph fter th neral	n: T	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur	y 28b. Time		ment of the same	28d. Describe how i		,/
Division	Attendia death. ctor: A y the fu	catio	2 Accident investigation in Suicide 6 Could not	ation	uni. At homo form	M 1 🗆 Y	res 2 □ No	28f. Location (Stree	t and Number or O	en l Courte Mumber
<u>≥</u>	tal or At rs after c el Direc ed in by	Certification;	4 Homicide determin	building, etc	iry - At home, farm, s c. (Specify)	treet, ractory, office		City or Town, S		rai noute Number,
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of xeminer: On the basis of and manner sta	examination and/or	ith occurred at the tim nvestigation, in my op	e, date and place, pinion, death occurr	and due to the caused at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the vithing To the comp	ž	29b. Signature and title of certifier	100000	11 1	29c. License			Date signed (Month	
	, N		Pow an	moses t			vv 1305		4.03	4 . 4 . 4
_			30. Name and address of person v	NOSUS M	D 130	5 York	RA L	urhemi	16 MD	2093
	Sta Registr		31. Date filed (Month, Day, Year)	32. Poistra	ar's Signature	licel ?				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Richard Reece Barrett 4:20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** FOW LUE constance c 7. Age (In yrs. last birthday)

Months Days Hours Min.

7. Age (In yrs. last birthday)

7. Age (In yrs. last birthday)

Months Days Hours Min.

7. Age (In yrs. last birthday) 5. Social Security Number Funeral 6 Sex 9. Birthplace (State or Foreign 1**∑** M 2□ F 042-24-4707 Director California Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28e-f show treumatic event, the Medical Exercise errors to redified at 1 ☐ Yes 2 ☐ No Director Baltimore Maryland Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 220 Deer Fox Lane 21093 U.S.A. death 1 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ò 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, ilt. Pages 1 and 2 should be filed within itment of Health and Mental Hygtene. It ent: If item 27 Is marked other than ** Elementary/Secondary (0-12) College (1-4or 5+) 12 Advertising Executive Advertisina 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Richard C. Barrett Jovita Reece 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pricilla F. Barrett, Wife 220 Deer Fox Lane, Timonium, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) injury or Hilltop Service Corp. 02/09/2005 Towson, Maryland permit.
Deporte
Importe
any inju 21. Signature of Funeral Service bic ins 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. argas 1050 York Road, Towson, MD 21204 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or nearl failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of) **Examiner** HOUL, RESPIRATORY DISTRESS Sequentially list conditions Dive to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of): Records, P.O. Box 68760 attending physician be Physician/Medical as the IF FEMALE: esn nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CORONARY ARTERY DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2【 No 24a Was an 2X No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2X No filled in by the funeral 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 2005 It speeds Registrar

State of Maryland / Department of Health and Mental Hygien 05 1 - For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 02 0230gm 05 /Medical 4b. City, Town, or Location of Death County of Death institution, give street and number Examiner County olumbia, Howarc 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. **Funeral** Days Hours 172-01 Director New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examiner must be notified at MD Howard 1 ☐ Yes 🎗 🗆 No Dayton Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 14269 Triadelphia Mill Road 23a 21036 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 2 Married Maryland 21215-0036 ŏ 1 ☐ Yes 2 No White Specify Specify: 3 Widowed 4 Divorced Year or Dates "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Finance Co. Supervisor GAC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be if Health and Mental ဂ္ဂ Ralph V. Blake Hulda Victoria Carlson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2913 Ordway Drive, Ellicott City, MD 21047 Joanne Burgio/ Daughter 3altimore. 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
MeadOwridge Date 20c. Location - City or Town, State Department of H Important: If ite any injury or of once. * 4 ☐ Donation 5 ☐ Other (Specify) Park 02-11-2005 Elkridge Maryland 2. Name and Address of Facility Gary L. Kaulman Funeral Home at Meadowridge Memorial Park Memorial Park 21. Signature of Funeral Sen 7250 Washington Blvd., Elkridge, Maryland 21075 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Week STROK 0 Sequentially list conditions, or as a consequence of) Examiner Tany, reading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) P.O. the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à pe cate has been sig , page 2 should b 2 X100 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 21X No 1 Yes of Vital 2. No 1 Tyes director Be 25. Was case referred to medical 26. Place of Death Check on one examiner? 2 No 1 XInpatient Other: 1 🗆 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28b. Time of After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the ! 29b. Signature and title of çertifier 29c. License number 29d. Date signed (Month, Dav. Year) sted cause of death (Item 23a) (Type, Print) 30. Name and address of person hia 100 32. Registrar's Signature Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pamela E Southoul, MD 111 Pe

31. Date filed (Month Day, Year) 32: Signature

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

February 04, 2005

			1- State of Ma		artment of Health and i Tificate of Death	Mental Hygie	2005	03625
	a		Registrar 1. Decedent's Name (First, Middle, Last)	Cel	incate of Death	Reg.	No.	3. Time of Death
	Physic /Medi		Mary Agnes	Chisley		Month 2	6 05	6:10PM ^M
	Examir		4a. Facility Name (If not institution, give street and number)	0112.01.03	4b. City, Town, or Location of Death		4c. County of Dea	
	1			ome)	Halethorpe		Baltimo	ore
П	Funeral Director		1 N OF	e (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye) 7/1/191	9. Bir	thplace (State or Foreign ountry) 'Y Land
			216-32-8844			1/1/191	.9 Mai	yrand
	arylane show	L	10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	8a-fs	ecto	Md. Baltimore	Halethor	ре			1 XYes 2 □ No
	with the	Dire	10e. Street and Number		10f. Zip Code		Citizen of What Co	ountry?
	death	Funeral Director	2040 Northeast Ave.	Ever in U.S. 13. V	21227 Vas Decedent of Hispanic Origin? (Si		ISA 14. Race - Ame	encan Indian
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 Is marked other then "neturel", or Items 23a or 28a-f show other treumatic event, the Madical Examiner is ust the malified at	by Fun	Armed Forces? 1 X Never Married 2 Married 1 Yes, Give 1 Fyes, Give 2 Year or Dates:	10 I	Nas Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	te, etc.
21215-0036	2 hou	ted	15. Decedent's Education	16a. Deced	ent's Usual Occupation	166	. Kind of Business	
218	thin 7 9.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	life f	kind of work done during most of world OO NOT use retired)	king		,
	filed wi Hygien kher th		12	D	omestic		Home	
and	d be findal Hed ot	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Maid		
Maryland	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, the Mental	은	John W. Chisley 19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	Mary g Address (Street and Number or Rui		hisley	Zin Code)
	1 and 2 Health ar lem 27 Is		Rona Collins Daughter		Northeast Ave			
ore,	es 1 a of He of He fitem		20a. Method of Disposition	20b. Place of Dispos cemetery, crem	sition (Name of patory or other place)		. Location - City or	
ij	nit. Pages artment of l ortent: If it injury or o		1 Burial 2 Cremation 3 Removal from State '4 Donation 5 Other (Specify)	Arbutus	Mem.Park 2/10	/05 A	rbutus,	Md.
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr <u>once.</u>		21. Signature of Funeral Service Licensee Lloyd M. Estep	E 1	Name and Address of Facility step Brothers 300 Eutaw Plac	Funeral	Ser,P.A	21217
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	nie dealii. Do not ente	in the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician	0. 1	Immediate Cause (Final disease or condition	ic obs	tructive lus	9 disea	20	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as:	a consequence of):		0		20 July
Ď,		er	Sequentially list conditions, b. Due to torias:	s consequence of:				
	d d ansit	Examiner	lt any, tagoing to in modiate cause. Enter Underlying Cause (Disease or injury that initiated events					
ó	be execute sician and burial-trans		requising in death\ Leas	a consequence of):				
68760,	icate but bhysiciles the but	edicai	d					4
	entific ding p		IF FEMALE:	of a room an au				
Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of deli Month	ivery Day Year
0	at the de by the datached	hysi	1 ☐ Yes 2 € Ho 4 ☐ Fregnant at 9 ☐ Unknown 9 ☐ Unknown		Otties (specify)			
S, D	es that igned b	by P	Part II. Other significant conditions contributing to death but			23e. Did tobacc	o use contribute to	the cause of death?
brd	w require been signal	ted	Hypertesion, Atriol	Fibrilla-	ten	1 Yes	2 □ No 3 □ Pr	obably 4 Unknown
Vital Records,	e law r has be	Completed				24a. Was an autopsy	prior to c	topsy findings available completion of cause of
a E						performed	death?	
Z.	sicien: certific rector,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatie		Other	h Check only one)		
of	ding Phys	on: T	27. Manner of Death 28a. Date of Injur		28c. Injury at Work?	me 5 Hesidence 28d. Describe how in		cify)
Division	Attending Physicien: r death. ector: After this certific by the funeral director,	atio	1	Year) Injury	Work? M 1 Tyes 2 No			
ivis	after death after death Director: /	Certificati	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju building, etc	ry - At home, farm, stre . (Specify)	et, factory, office	28f. Location (Street City or Town, St.	and Number or Ru ate)	ıral Route Number,
Ω	Hospital or 4 hours afte Funerel Dir tely filled in						·	
	To the Hospital or At within 24 hours after or to the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of Medicel Exeminer: On the basis of and manner stall	examination and/or invi	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Z	29b. Signature and title of certifier	0.0	29c. License number		Date signed (Month	
4			rogge a. GIVY	m.D.	D31726	0	2-7-0	١
	8(,		30. Name and address of person who completed cause of de Ragfatty, Givg's Marsh 131. Date files (Month, Day, Year) 32. Figistra FEB 0 8 2005	ath (Item 23a) (Type, P	Maiden Phoice	LA- (aten/vil	6 MD 21778
٠.	Sta	te	31. Date files (Month, Day, Year) 32. Figistra	r's Signature	7 -		y-01	_,
	Registr	ar	FEB 0 8 2005	a & Ag	and a			

			For State Registrar		State of	f Maryla	and / Dep <i>Ce</i>	artment of I	Health a	and Ment		jiene 0	05	03626
	o Discosio		1. Decedent's Name	(First, Middle, La	st)						ate of Deal	th		3. Time of Death
	Physic /Medi				on Snow		rter			FÉ		2005	Year	7:30a M
	Exami	ner	4a. Facility Name (If	not institution, giv	e street and nun	nber)		4b. City, Town, o	or Location o	of Death		4c. County	y of Death	
			8304 McDo	onogh Ro				Pikes		0411-			1timo	
L	Funeral Director		219-05-896 Usual Residence of D	62	M 2 F	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min. 8. D. MA	ate of Birth fonth, Day, R 5,	1 ^{year)}	9. Birthi Coul Mary	place (State or Foreign ntry) Land
	yland now			10b. County		10c.	City, Town or Lo	ocation					1	10d. Inside City Limits
	the Marylar 28a-f show	ţo	Maryland	Balt	imore			Pikesvil	11e					1 ☐ Yes 2] No
	th the	ire	10e. Street and Num					10f. Zip Code			1	0g. Citizen of	What Cour	ntry?
	ath w	la I	8304 McDo	onogh Ro	ad			2	21208			USA		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, Ir.e. Marical Examples: Mat be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed 4		12. Was Dece Armed For 1 Tyes If Yes, Giv Year or Da	ces? 21 No e		Was Decedent of Hard Person of Hard Person of Hard Person of Person of Hard Pers		gin? (Specify Y n, Puerto Rican	es or No- , etc.)		ce - Americ ck, White, y: W	
5	72 h 'natu	etec	(Specif	15. Decedent's E	tucation de completed)		16a. Dece	dent's Usual Occup	ation during most	t of working		16b. Kind of B	usiness/In	dustry
121	within ne. han	Completed	Elementary/Second		College (1	4or 5+)		kind of work done DO NOT use retired				Moon		
5	filed v Hygie other t		17. Father's Name (F	irst Middle Last	4		G	eneral Ma	nager	er's Name <i>(Fir</i> s	A Adiabatia - A		zine	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, ILe M.	o Be	Wilton S			Sr						naiden Suman	ne)	
7	Shoul nd Me mark	2	19a. Informant's Nan			Dr.	19b. Mailir	ng Address (Street		ile Ber		City or Town	State Zin	Code
S	1 and 2 Health a tem 27 is	į į	Margaret					McDonogh				e, MD 2		, code)
Baltimore,	of Heal		20a. Method of Dispo			20b		sition (Name of matory or other place		Date		20c. Location -		own, State
E	permit. Pages Department of I Important: If its any injury or or once.		1 □ Burial 2 🔀 `4 □ Donation 5	Cremation 3 ☐ ☐Other (Specif		raco		ematory,		2/4/05		Balti	moro	MD
alti	permit. Pag Department Important: I any injury o	1	21. Signature of Fund	eral Service Licer	ISOO M	11		remarion				Darti Land T	more'	MD
<u> </u>	89 5 2		Daw	m F. Mci	Ona Id	MOK		299 Frede	rick	Road F	Paltin	nore M	ne. D 212	228
			23a. Part1. Enter the shock, or heart	disease, or com failure. List only	plications that ca one cause on ea	used the de ich line.	ath. Do not ent	er the mode of dyin	ng, such as	cardiac or resp	iratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (F	inal	a		Luni	1 Can	cer				- 1	Onset and Death
	/Medical Examiner		resulting in death)	- (Due to (d	or as a cons	equence of):							1973
		<u>.</u>	Sequentially list cond	titions,	b. Due to (c	or as a cons	equence of):							
/	nsit	i i	Sequentially list condificant, leading to immoduse. Enter Underly Cause (Uisease or in that installed in the conditions)	/ing	240 10 (0	71 a3 a coms	equence or,							
Ć,	rate be executed oblysician and the burial-transit	Examiner	that initiated events resulting in death) La		Due to (c	or as a cons	equence of):						-	
8760,	cate be ohysicia the bur	dlcai			d									
9	rtifical ng phy as th	Medi	IS SELVI S									-		
Вох	death certifica e attending plad for use as t	Physician/Me	IF FEMALE: 23b. Was decedent p		23c. If yes, outo	ome of preg		Ectopic pregnancy	,				te of delive	ory
0.		sici	in the past 12 m 1 ☐ Yes 2 ☐ I 9 ☐ Unknown			int at time of		Other (specify)	-			Moi	nth	Day Year
Θ.	by tac		Part II. Other signific	ant conditions o			anulting is the				a. Didui			
ds,	es Be	l by	raitii. Odler signiic	ant conditions c	onthouting to dea	ath but not n	esuiting in the ur	idenying cause givi	en in Part I.	23				e cause of death?
Ö	w requir been si should	etec								-	[42] 18:			ably 4 Unknown
3ec	e las has je 2	Completed								24	la. Was an autopsy	/ D	rior to con	osy findings available npletion of cause of
a	icien: The l certificate ha rector, page	e Co	25 Was	4.5								No 1	leath?	2 🗆 No
₹	Physicien: this certific ral director,	o Be	25. Was case referred examiner? 1 ☐ Yes 2 🛣 No		Hospital:		7500	Othe		of Death (Chec	400000000000000000000000000000000000000		-	
of	g Phy ar this eral d	H- 1	27. Manner of Death		28a. Date of	Injury	ER/Outpatien 28b. Time of	28c. Injun	4 LI Null	rsing Home 5		nce 6 ∐Othe w injury occurr)
ion	Attending or death. ector: After by the fune	atlo	1 XNatural 2 ☐ Accident	5 Pending investigation		, Day Year)	Injury		k? Yes 2∐N			, ,		
-	or Attendated after death Director: /	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place o	of Injury - At g, etc. (Spec	home, farm, stre cify)	eet, factory, office		28f. Lo	cation (Stre	eet and Numbe State)	er or Rural	Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 (Check only 2	Certifying Ph	ysician: To the tiner: On the bas and manne	sis of examil	nowledge, death nation and/or inv	occurred at the timestigation, in my op	ne, date and pinion, death	f place, and du- h occurred at th	e to the cau	use(s) and mai te and place, a	nner as sta	ated. the cause(s)
	ro th vithin ro th compl	Me	29b. Signature and tit	le of certifier				29c. License	e number		29	d. Date signed	i (Month, D	Day, Year)
•	/		> \(1/	7	í	M.D.	D	536	554	F	Physi	<u> </u>	2005
	b		30. Name and addres	of person illo	completed cause	of death (Ite	em 23a) (Type, i	Print)					, -,	,2005
			VAO-	YAO Z	HU, 6	565	NICE	arles St	.#2	03, B	alti	more.	mD:	21204
	Sta		31. Date filed (Month,		32. Re	strar's Sign	nature				/			
Ų.	Registr		F	EB 082	005 🎜		K 4	Carl's						44
DHN	MH 17 Rev 1/20	001			CONTRACTOR OF THE PARTY OF THE		-	Sept						13
							ORIGINA	L						

			1 - Stete Registrar		laryland / Dep <i>Ce</i>	ertificate of	Health and N Death	Re	g. No.	5 03627
	Physic		1. Decedent's Name (First, Middle, La Emma B. Curlo	•				2. Date of Death Month February	Day Ye	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, given)	4b. City, Town,	or Location of Death	1 evidenti	4c. County of [
A		eğ.	Franklin Square	e Hospital			sville		Balti	more
2	Funeral Director		219-07-3590	Gex 7. Ag 1 □ M 2 ▼ F	ge (In yrs. last birthda) 85 Yrs.	Months Days		8. Date of Birth (Month, Day,) Oct. 21,	(ear) 9. 1919 N	Birthplace (State or Foreigr Country) Maryland
	and		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	the Mary 28a-f sho	ector	Maryland Baltin	nore			e Marsh			1 □ Yes 2 No
	3c or	I Dir	10903 Old Phi	adelphia	Road	10f. Zip Code	21162	100	g. Citizen of Wha U.S.A	•
936	within 72 hours after death with the Maryland ane. than "natural", or Itams 23s or 28a-f show the Modical Exeminer. Mst.be molified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 🎗 Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Yes If Yes, Give Year or Dates:	Ever in U.S. 13	Was Decedent of If Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, V	• American Indian, Vhite, etc.
21215-0036	be filed within 72 hours ital Hygiene. id other than "natural", evant. I're Madical Exa	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Giv	edent's Usual Occue e kind of work done DO NOT use retire	upation of during most of work od)	ing	6b. Kind of Busine	
212		Comp	Elementary/Secondary (0-12) 12th Grade	College (1-4or	5+)	omemaker			Own 1	Home
Maryland	should be filed nd Mental Hygi markad othar matic evant,	To Be	17. Father's Name (First, Middle, Last Andrew Bowers				18. Mother's Nam	e (First, Middle, Ma	iiden Sumame) TNAME UN	known)
lary	S S S		19a. Informant's Name/Relationship (Турө, Print)	19b. Mai	ing Address (Stree	at and Number or Rur			
	s 1 and 3 f Health itam 27 other tra		Mr. Lars Curley	(8)	on) 540	8 Norrisi	ville Rd.,			21161
nor	S - = 0		20a. Method of Disposition 1 💢 Burial 2 🗆 Cremation 3	Removal from State	20b. Place of Disp cemetery, cre				c. Location - City	
Baltimore,	permit. Page Department of Important: If any injury or once.		* 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice		St. John	S Epus. C 2. Name and Addr	em. 2/5/2 ess of Facility Sch	2005 Ka Limunek F	ingsvill uneral H	e, Maryland Iomes
<u> </u>	89 = 28		Stefanie	Rene	2el	9705 Bela	iir Rd., B	altimore,	MD 2123	36
	Pnysician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aASC	VD	iter the mode of dy	ing, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
8760,	Examiner be executed by physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Pusta Due to (or as	a consequence of): a consequence of): a consequence of):	Bleed				
.O. Box 68	death certif e attending od for use as	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify)	:y		23d. Date of Month	delivery Day Year
٣.	Se Go	by	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the I	ınderlying cause gr	ven in Part I.		co use contribute	to the cause of death? Probably 4 Gunknown
al Records	The law ate has t page 2 s	Completed						24a. Was an autopsy performer	prior	
Vital	Physician: Th r this certificate ral director, pag	Be c	25. Was case referred to medical examiner?	Hospital:		_ Ott		Check only one)		
Division of	ttanding Physician: Jeath, Tor: After this certific the funeral director,	tion; To	1 Yes 2 No 27. Manne of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry 28b. Time o	f 28c. Inju	her: 4 Nursing Hol ry at rk? Yes 2 No	me 5 Residenc 28d. Describe how		pecify)
Divisi	or Al	Certification:	3 Suicide 6 Could not be determined		ury - At home, farm, st c. (Specify)			28f. Location (Stree City or Town, S	et and Number or State)	Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Ph	ysician: To the best of the basis of and manner sta	of my knowledge, deal examination and/or in	h occurred at the til vestigation, in my o	me, date and place, a opinion, death occurr	and due to the caus ed at the time, date	e(s) and manner and place, and d	as stated. lue to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier			29c. Licens	se number	29d.	Date signed (Mo	onth, Day, Year)
}	Λ		M, MD			135	7727		2/4/0	T
	'\		30. Name of address of person who			d Es	7727 sed m	02117		
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 8	32. Regultra	ar's Signature	porte		11		

org	e Colema	an	_	000	State of							lental Hv		gible.		
			1 - State Registrar		Clate of I	viaryiai		rtificate			aliu iv		Reg. No.	05	0362	28
	Physici	2 D	1. Decedent's Name (First, M.	iddle, Last)							2. Date of De	ath	Vana	3. Time of De	eath
	/Medic		George O		oleman							Januar	y 31,	2005	12:20	P
	Examin	er	4a. Fecility Name (If not instit				- 4			Location o				inty of Death		
	Funeral		Coopers Lane 5. Social Security Number				et last birthday)			tsvil		8. Date of Bir	th		George's	
	Director		577-48-8674 Usual Residence of Deceden		x 7.] M 2 ☐ F	69	Yrs.	Months	Days	Hours	Min.	Nov. 8	1935	Cou	place (State of F ntry) D Washing	Con,
	yland		10a. State 10b. Con	inty		10c. Ci	ty, Town or Lo								10d. Inside City	Limits
	hours after death with the Maryland turel', or Items 23a or 28a-f show al Exertinest be notitied at	Funeral Director	MD Prin	nce G	eorge's				heve	rly					1 X Yes 2	!□No
	3a or	Ö	6231 Landover	Rd.				10f. Zip		785			10g. Citizen	of What Cou • S • A	ntry?	
	death	nera	11. Marital Status		12. Was Decede Armed Force	nt Ever in U	I.S. 13.	Was Deced			gin? (Sp	ecify Yes or No Rican, etc.)	- 14, F	Race - Ameri	can Indian,	
36	urs after II', or Ite	by Fu	· 1 ☐ Never Married 2 🛣 I 3 ☐ Widowed 4 ☐ Divor		1 XYes 2 [If Yes, Give Year or Date:	□No		ir Yes, spec 1 □ Yes 2			, Puerto	Rican, etc.)		Black, White,		
9-0	72 hour natural	ted	15. Dece	dent's Edu	cation		16a. Dece	dent's Usua	I Occupa	ation				Bla Business/In		
21	5 5	Completed	(Specify only his		e <i>completed)</i> College (1-4c	r 5+)	(Give	kind of wor DO NOT us	k done a e retired,	furing most)	of work	n <i>g</i>			,	
121	e filed within I Hygiene. other than rent, II e M	Co	12th 17. Father's Name (First, Mide	do (a a a)				Poli	ce 0	ffice				nment		
lanc	uld be fi lental H rked ot ic ever	To Be	Almond Coler								r's Name erin	e (First, Middle, .e	Maiden Sum Ray	name)		
Maryland 21215-0036	d 2 shouth and N 17 is mail		19a. Informant's Name/Relati Marilyn L. Col				19b. Mailir	g Address	(Street a	nd Numbe	r or Rura	Noute Number	r, City or To	vn, State, Zip	Code)	
	permit. Pages 1 an Department of Heali Important: If item 2 any injury or other		20a. Method of Disposition			20b. F	Place of Dispo					ate Til		on - City or To	own, State	
Baltimore,	Page nert o int: If		1 🌠 Burial 2 ☐ Cremati `4 ☐ Donation_5 ☐ Othe		emoval from Star						2/10	/2005		-		
alti	permit. Pa Departmen Important: any injury		21. Signature of Funeral Serv	ice Licens	A.							. Jenki				
	207 29		23a, Part1. Enter the disease	M	rew							andover		20785		
	/Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cissase or injury that initiated events	a a b	Due to (or a	s Conseq	uenca).								Approximate Interval Betwee Onset and Dea	en ath
8760,	ate be executed thysician and the burial-transit	cai Exa	resulting in death) Last		Due to (or a	s a conseq	uence of):									
P.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23	3c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal	I death 3 🗌	Ectopic pre Other (spe				M74	4	Date of delive	ry Day Year	r
	res that signed b	by Pr	Part II. Other significant cond	litions con	tributing to death	but not resi	ulting in the un	derlying ca	use give	n in Part I.		23e. Did to	bacco use co	entribute to th	e cause of death	h?
Records,	w require been sig should b											1 🗆 Y	es 2 No	3 Prob	ably 4 □Unkr	nown
al Rec	The ate h page	Completed										24a. Was a autops perform	y	prior to cor death?	osy findings avai npletion of cause 2□ No	lable e of
Vital	Physician: this certificanal director,	o Be	25. Was case referred to med examiner? _1 XYes _2 No	1	ospital:		ED/O		Othor	_		(Check only or		-		-
of	g Phy er this eral d	n: To	27. Manner of Death		28a. Date of In	ury	ER/Outpatient 28b. Time of		c. Injury :	at at	-	ne 5 ☐ Reside 8d. Describe ho			SCENE	
Division	Attending Ir death. ector: After by the funer	Certification:		ding stigation ld not be	(Month, D	05	12:1			es 2 XV	0	vehi	cle s	truck	0	
Div	Blor A safter il Direction by	Sertif	4 Homicide dete	emined	28e. Place of Ir building, e	tc. (Specify	aclu		office			3 City or Town	reet and Nun	DOPC: 5	Route Number	
		edical	29a. Certifier 1 Certification Check only cone)	ying Phys al Examin	ician: To the bes er: On the basis and manners	t of my know	wledge death	occurred at	the time	, date and nion, death	place, a	nd due to the ca d at the time, d	ause(s) and nate and place	nanner s sta	ated. the cause(s)	(()
	To the within To the compl	-	29b. Signature and title of cert	fier		0 -		29c.	License	number		2	9d. Date sign	ed (Month, L	Day, Year)	
•	13		tole,	Lia	to	lli	صدر		O.C.	M.E.			Febru	uary 0	1, 2005	
	10		30. Name and address of pers			death (Item			C+	o+ D	_ 1 : •					
	_s Stat	е	31. Date filed (Month, Day, Ye	ar)		rar's Signat		renn :	otre	et, B	alti	more, N	arylar	nd 2120	OI	
	Registra	r	FEB 0	8 200	J. Allenda	W X	s popular	4								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 29, 2005 **Physician** January 6:00 P M Beverly Jean Crawford /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges Mount Rainier 3116 Varnum Street If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, July 19 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Pennsylvania Days 1 ☐ M 2 🛛 F 65 167-32-4054 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County or 28a-f show item 27 is marked other than "na ural", or Items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at Yes 2 No Directo Maryland Prince Georges Mount Rainier 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20712 3116 Varnum Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 ☐ Widowed ★ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene, important: If item 27 is marked other than "ns any Injury or other traument. Elementary/Secondary (0-12) College (1-4or 5+) Organized Labor Consultant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Jones Leonard King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11619 Sequoia Lane; Beltsville MD 20705 Stephanie Jones - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition P☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 2/8/2005 Brentwood, MD ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility Fort Lincoln Funeral Ho 3401 Bladensburg Rd; Brentwood MD 20722 T. Vlobe Mellen Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the peath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a conseq **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐XNo detached 9 Unknown 9 🗆 Unknown s been signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 2 No has this certificate 1 Yes funeral director, Be 26. Place of Death (Check only one) 25. Was case referred to medical examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Ho 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 Accident filled in by the within 24 hours efter deat To the Funeral Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Fune completely fi Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10301 Georgia Ave Suite #205; Silver Spring MD 20902 Charles Boice MD 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

			For Stata Registrar	State of Mar		Department of H Certificate of I			giene Reg. No:	005	03630
	Physici	an	Decedent's Name (First, Middle, Las Louise	t)		Curtis		2. Date of De Month Februari	Day	Year 2.005	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	h	4c.	County of Dea	th
			- 1-11-0-3	theare	In yrs. last bin		1MOC U If Under 24 Hrs.	8. Date of Bir	th	NA	thologo /State or Foreign
	Funeral Director		5. Social Security Number 6. Social Security Number 1	ox M M F 7. Age (1	,	Yrs. Months Days	Hours Min.		v. Year)	9. 6%	thplace (State or Foreign buntry) Md
			Usual Residence of Decedent								
	ehow	ō	Md. 10b. County	1	0c. City, Town B	altimore					10d. Inside City Limits 1√□ Yes 2 □ No
	the N	Director	10e. Street and Number		-	10f. Zip Code			10g. Citiz	zen of What Co	4.
	th with	al DI	338 Suter Road			21:	228		U	SA	
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23a or 28e-1 ehow he Medical Examinar rust Les notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Even Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 💆 No	ispanic Origin? (S an, Mexican, Puerl Specity:	Specify Yes or No to Rican, etc.)		14. Race - Ame Black, Whit Specify: B	te, etc.
2-0	72 hours "neturel", dical Exa	eted	15. Decedent's Ed (Specify only highest gra		16a.	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most of wor	rking	16b. Kir	nd of Business	/Industry
121	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Seamstress	i)		Leb	ow's	
	should be filled withir and Mental Hygiene. e marked other then umetic event, the M	Be Co	8th grade 17. Father's Name (First, Middle, Last)			Dearing CE CDD	18. Mother's Nar	me (First, Middle,	Maiden	Sumame)	
/lar	should be and Mental I amarked o	To B	Ulysses	Jenkins	3		Mol	lie		Cart	er
Maryland	C1 (0 = B	8	19a. Informant's Name/Relationship (7			. Mailing Address (Street					Zip Code)
	is 1 and 2 of Health item 27 other tr		William Curtis, 3	Jr. Hus	oand 20b. Place of	338 Suter R Disposition (Name of		timore,		21228 cation - City or	Town, State
nor	Pages nent of H ant: If ite ary or of		1 Burial 2 Cremation 3 □ '4 Onnation 5 Other (Specify		cemeter	y, crematory or other plac ison Forest		-05		1131	lls, Md.
Baltimore,	permit. Pages Department of Importent: If i any injury or one		21 Signature of Funeral Service Live		0	22. Name and Addre	ss of Facility	Bal	Ltimo	re, Md North	. 21202
	⊈ ⊡ E e ol		23a Att. Enter the disease, or com	Value	e death Do					NOL CIT A	Approximate
	di marana		sylock, or heart failure. List only	one cause on each line.							Interval Between Onset and Death
1	Pnysician /Medical		diseale or condition resulting in death)	a. Due to (or as a	MNA(217				2 WEEKS
	Examiner		Sequentially list conditions	b							
	be sit	iner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause, Olisease or injury	Due to (or as a c	onsequence	of).					
	axecut n and al-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a c	consequence	of):		W. 21 J. 854 J. 854			
58760,	icate be executed physician and s the burial-transit	dical		d							
_	ntifical ng ph		IF FEMALE:	-							
P.O. Box	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	′		2	23d. Date of de Month	livery Day Year
	res that thighed by	by Pf	Part II. Other significant conditions of			n the underlying cause giv	en in Part I.				the cause of death?
ords	w require been sig should b	ted k	BREAST	CANCER	۷			1 🗆	Yes 2]No 3 □ P	robabiy 4 Unknown
Records,	ician: The law r certificate has be rector, page 2 sh	Completed	PLEURA	L EFF	1510	\mathcal{N}		24a. Was auto perfo 1 \(\triangle Yes		prior to death?	utopsy findings available completion of cause of
of Vital		Be C	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o		10100	
of V	Physician: this certifical	မ	1 ☐ Yes 🤾 No	THE RESERVE OF THE PARTY OF THE	2 ER/O		4 🗀 Nursing F	lome 5 Resi			ecify)
o uc	ding P. After I	ilon:	27. Manner of Death Natural 5 Pending investigation	28a. Date of Injury (Month, Day)	/ear) 28b.	Time of 28c. Injury Wor	yat k? Yes 2 □ No	28d. Describe	now injury	y occurred	
Division	Attending r death. sctor: Afte by the fune	fical	3 Suicide 6 Could not b	e 28e. Place of Injury	- At home, fa	arm, street, factory, office		28f. Location (Street and	d Number or R	ural Route Number,
D	s afte el Dire ed in b	Certification:	4 Homicide determined	building, etc.	(Бресіту)			City or To	wii, State)		
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical			xamination an	e, death occurred at the tired or investigation, in my o					
	within To th compl	Me Me	29b. Signature and title of certifier) ws		29c. Licens				e signed (Mon	
	116		30. Name and address of person who	completed cause of dea	th (Item 23a)	(Type, Print)	01165	>	1451	YICHTCY	3 4 2005
	10		EBENFZER QU	AINOU S	TAGA	(Type, Print) FS HEALT	TH CARE	BALI	imo	rt N	10 21228
		ate	31. Date filed (Month, Day, Year)	32. Registrar	Signature	H. Sperke	,				
	Regist	rair	FER (10 4005		- 7					

CURTIS, COULSE

			1 _ State		artment of Health and Mo tificate of Death	ental Hygien Reg. N	2005 03631
			Registrar 1. Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physici		Ronald Nelson Coffee		-	February	3 2005 1:07 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		c. County of Death
	E X dji i i i i	ĢI	MORTH ARUNDEL HOSP	ITAL	GLEN BURNIE		ANNE ARUNDEL
	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)
	Director		196-28-7296	67 Yrs.	Minute Days Floors Will.	Oct. 31,19	937 PA
	pun *	-	Usual Residence of Decedent 10a. State 10b. County 10c	c. City, Town or Lo	cation		10d. Inside City Limits
	aho	ō	MD Howard	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Elkridge		1 □ Yes 2 □No
	28e-1	Director	10e. Street and Number		10f. Zip Code	10g. C	itizen of What Country?
	with Be or	ä	6906 Old Dorsey Road		21075		U.S.A.
	leath	era	11 Marital Status 12. Was Decedent Ever	in U.S. 13. V	Was Decedent of Hispanic Origin? (Spet f Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - American Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 271s marked other than "netural", or Items 23a or 28e-f show or other traumetic event, Ite Medical Examinational be nutified at	by Funerai	Amed Forces? 1 □ Never Married 2 → Married 3 □ Widowed 4 □ Divorced Amed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: 194		f Yes, specify Cuban, Mexican, Puerto F I □ Yes 2[★No <i>Specify:</i>	lican, etc.)	Black, White, etc. Specify: white
Maryland 21215-0036	tural	edt	15. Decedent's Education	16a, Deced	dent's Usual Occupation	16b.	Kind of Business/Industry
15	nin 72	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done during most of workin DO NOT use retired)	9	
212	d with giene rr tha	mo:	8 8	Body	and Fender Painte	r Au	itomotive
פ	l be filed within ntal Hygiene. ed other than event, It a M.	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Maide	n Sumame)
<u>a</u>	should b ind Ments marked umetic e	70	John J. Coffee		Anna R	. Koch	
ar.	2 sho and Is ma		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Number or Rural		
≥ 3	and ealth m 27		Mrs. Linda Coffee / wife		Old Dorsey Road, I	-	
<u>o</u>	ges 1 t of H If ite or ot		1 X Burial 2 Cremation 3 Hemoval from State		natory or other place)		Location - City or Town, State
Itimore,	t. Pa rtmen rtant: njury		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Bethel Ce	,		Meade, MD
Ba	permit. Pages 1 and 2: Department of Health ar Important: If item 27 Is any injury or other trau		21. Signature of Fundamental Service Licensee		Name and Address of Facility Sin		
			23a. art1. Enter the disease, or complicating is that caused the shock, or heart failure. List only one cause on				Approximate
			shock, or heart failure. List only one cause on such line.	1	1		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a con	al la	11 Wife		
	Examiner		Due (0 (0) as a con	nisequence or,			
	197	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	nsequence of):			
	outed ansit	Examiner	Cause Disease or injury that initiated events c.				
o Ô	an ar urial-t	EX	resulting in death) Last Due to (or as a cor	nsequence of):			
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai	d				
9	e as	Mec	IF FEMALE:				
Вох	leath certific attending p I for use as I	ian/	23b. Was decedent pregnant in the past 12 months?	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
o.	res that the de signed by the a i be detached f	by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time	or death 3L	Jother (specify)		
٦.	that the by detail	ᆔ	Part II. Other significant conditions contributing to death but no	t resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Records,	uires sign lid be		Comman Arten	Si sease		1 □ Yes	2 □ No 3 □ Probably 4 □ Unknown
Ö	w require s been si should t	iete	Dialadas Maltitus			24a. Was an	24b. Were autopsy findings available
	The tav te has age 2	Completed	Fundance	\		autopsy performed? 1 ☐ Yes 2 2 N	prior to completion of cause of death? 1 □ Yes 2 ▼ No
Vital	ilcian: Th certificate rector, pag	0	25. Was case referred to medical		26. Place of Death		
	Physici this ce al direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatien	t 3 DOA Other: 4 Nursing Hom	ne 5 🗆 Residence	6 □Other (Specify)
0 _	ng Ph fter th	:uo	27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury	28c. Injury at 2 Work?	8d. Describe how inj	ury occurred
Sio	Attendideath. ctor: A y the fu	cati	2 Accident investigation		M 1 Yes 2 No		
Division of	l or Ati after d Direct J in by	Certification:	3 ☐ Suicide determined 28e. Place of Injury - building, etc. (St	At home, farm, stre pecify)	eet, factory, office	City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated				
	o the ithin 2 o the omple	Mec	29b. Signature and title of certifiers		29c. License number	29d. D	ate signed (Month, Day, Year)
	F 3 F ŏ		1 / 1 / 1 00 11 .	116	Marcia.	FAL	mon 372 2005
	_		30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print)	t Ch	1 mind 2 54117
	17		Julie Ciana Phain 1	115 30	1 N. Hospital Dr	6len	Burne Mh
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's S	Signature		1	7.
	Registr	ar .	FEB 0 8 2005 Mana	to page			X1061

State of Maryland / Department of Health and Mental Hygiene Reg. No. 005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 5.20AN Care 0 Vasseni 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Morningside Assisted Living Hanover Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1-3-1908 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 💢 F 97 Months 212-34-5306 MD Director Usual Residence of Decedent the Maryland 10c. City Town or Location 10d. Inside City Limits 10b County 10a State 27 is marked other than "natural", or items 23a or 28e-f show treumstic event, the Medical Examinar must be notified at Anne Arundel Severn 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 7883 Chestnut Leaf Road 21144 USA death v by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Menial Hygiene. Importent: If Item 27 is marked other than "natural; or Itan any injury or other treumetic event, the Medical Examinant Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify. white 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Home Owner Homemaker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vasseni Voeller Albert Wilkinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Colleen Donaldson/daughter 7883 Chestnut Leaf Road, Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition TABurial 2 □ Cremation 3 □ R

14 □ Donation 5 □ Other (Specify) 3 Removal from State Glen Haven Cemetery 2/4/05 Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature of Fu y-ral Service Lice M01364 1 Second Ave SW Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARTERY DISEASE Physician CORONARY disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 4 Pregnant at time of death 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. à 1 Yes 2 No 3 Probably 4 Donknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 26 No 25. Was case referred to medical 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Dother (Specify) LIV examiner' Other: Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🗌 Inpatient this 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Hospitel or Attending PI
 24 hours after death.
 Funerel Director: After the 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier FEB 02 2005 f person who completed cause of death (Item 23a) (Type, Print) Hary Millersville MD 21108 Neg 8601 Veterans Mohes 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar FEB 0 8 2005

DHMH 17 Rev 1/2001

		1	For State Registrar	State of	Marylan				ealth a Death	ind M	lental Hy	gi g n(0	3633
	Tr.		1. Decedent's Name (First, Middle, L	ast)							2. Date of De. Month	ath Da	y Yea		3. Time of Death
	ysician Iedical		James Colihan								01	28			6:00p
•	aminer		a. Facility Name (If not institution, g	ive street and num	ber)		4b. City	, Town, or	Location o	f Death		40	. County of D	eath	r
			Bedford Court						r Spr				Montgo		
Fund Direct			202-20-8410	Sex 7 1⊠M 2□F	7. Age (In yrs. 77	last birthday) Yrs.	If Under	Days	If Under : Hours	Min.	8. Date of Bin Month, Da 08-11	h y. 1922	27	Birthpla Counti	ace (State or Foreig
pug *		<u> </u>	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10	d. Inside City Limits
haryte	100														1 ☐ Yes 2√∑ No
the A	a to	3	MD Montgo	mery	5	ilver		ng ip Code		-		10a. Cit	izen of What	Count	rv?
h with			3700 Internation	al Dr.				20906				•	SA		
Ind 21215-0036 ba filed within 72 hours after death with the Maryland ital Hygiene. Indicate than "natural; or Itams 23a or 28a-f show	traminer must be natified by Funeral Director	A Language	11. Marital Status 1 ☐ Never Married 2 ☑ Married	If Yes, Give	ces? 2□No 19	48	it Yes, sp	edent of Hi ecify Cuba 2 RNo	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	•	14. Race - Ai Black, W Specify:		tc.
000 hours			3 Widowed 4 Divorced	Year or Da	tes: 19.	16a. Dece			ation			16h K			
7 2 Indi	alle le		15. Decedent's l (Specify only highest g	rade completed)		(Give	kind of w	ork done d use retired	durina most	of worki	ng	IOD. K	ind of Busine	55/11/01	ustry
d 212 filed with! Hygiene. other than	t. the Medical S		Elementary/Secondary (0-12)	College (1-	4or 5+)		ines	_	rber				Hair		
Hygi ether	event.		17. Father's Name (First, Middle, Las	st)					18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)		
arylan should ba nd Mental marked	To B		Thomas Colihan						He	1en	Wedro				
Mg 2nd 2	other traumatic		19a. Informant's Name/Relationship Karen Tedekis ()						l Route Number				Code)
or Hee		2	20a. Method of Disposition 1 Burial 2 □ Cremation 3	□ Pomovol from S	.	Place of Dispo	natory or	other plac	e)		ate		ocation - City		
Page ment ant: It	ury or		'4 □Donation 5 □Other (Spec		G:	ate of	Heav	7en		02-0	1-2005	S	ilver	Spr	ing
Baltimore, permit. Pagas 1 ar Department of Heal Important: If item	any injury once.		21. Signature of Juneral Service Lio	see	Vari	~/ I	Rapp	Fune	s of Facility ra1 & Ave S	Cre	mation r Sprin	Ser g M	vices D 2091	0	
	.8	(23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that ca y one cause on ea	used the deat ch line.	h. Do not ent								1	Approximate Interval Between
Physic	ian		Immediate Cause (Final disease or condition		My	ocardi	o Ini	Fract	ion					Ιi	onset and Death nimediate
/Medi			resulting in death)	Due to (c	r as a conseq	uence of):									
Exami		.	Sequentially list conditions,	b										1	
P :	ial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cases (Dis about in July that initiated events	Due to (d	ras a conseq	uence or):									
xecut	ul-tran	5	that initiated events resulting in death) Last	c. Due to (o	r as a conseq	uence of):								-	
68760, ficate ba executed physician and	the buria	1		·											
687 ificate g phys	as the	2	-	0.											
Box ath cert	for use a	a colored and a colored	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Feta nt at time of d	Ideath 3	Ectopic Other (s	pregnancy specify)					23d. Date of o Month		y Day Year
that the de			Part II. Other significant conditions	contributing to dea	ath but not res	ulting in the u	nderlying	cause give	n in Part I.		23e. Did to	obacco (use contribute	to the	cause of death?
ds, luires	عَ ۾	2	Congestive He	art Fail	ure						101	es 2	© No 3 □	Proba	bly 4 □Unknowr
Records,	page 2 should	Did.	Pacemaker Def	ibrilito	r						24a. Was	sy	24b. Were	autops to com	sy findings available pletion of cause of
- 0	page	5	Reflux Esopha	gitis								rmed? 2 🙀 No	death 1 🗆 Y	? 'es 2	!□ No
Vital F sician: Th certificate	Be (25. Was case referred to medical examiner?							of Death	(Check only o	ne)			
- × ×	al dire	2	1 ☐ Yes 2 🔀 No			ER/Outpatier			4XXIVU		me 5 Resid			pecify)	
	funera	5	27. Manner of Death 1 Natural 5 Pending		Injury , Day Year)	28b. Time of Injury		28c. Injury Work			28d. Describe h	ow inju	y occurred		
Sic tent leath	the f	3	2 Accident investigati 3 Suicide 6 Could not	he	d later And		М		Yes 2□1		206 Location /6	Stmat an	d Number or	Duml	Pauta Numbar
Division of Attending after death. Director: Afte	ed in by the funera		4 Homicide determine	200. Flace	of Injury - At high g, etc. (Specif	ome, farm, str y)	eet, tacto	ry, office			28f. Location (S City or Tox			Hurar	noute Number,
Div To the Hospital or A within 24 hours after To the Funeral Direc	completely filled in by			Physicien: To the laminer: On the base	sis of examina										
o the ithin 2	eldmo		29b. Signatural and title of certifier	uno matin			2	9c. License	number			29d. Da	te signed (Mo	onth, D	ay, Year)
7.87	2		buc Aum	1-0				D1	8726				-31-20		
·	0	-	30. Name and address of person wh	o completed cause	of death (Item	n 23a) (Tvoe.	Print)								
	か		Arthur Schoens					Dr.	01nev	MD	20832				
8-4	State		31. Date filed (Month, Oay, Year)		gistrar's Signa		р								
* Re	gistrar		FER AS	2005		£.	A.								

DHMH 17 Rev 1/2001

ORIGINAL

			• •	e of Maryland / I	Depa		ealth and I	Mental Hyg	_	03635
	4		Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day Yea	3. Time of Death
	Physicia /Medic		Phyllis Ann	n Dawson				Februar		2:14 P ^M
}	Examin	40	4a. Facility Name (If not institution, give street an	d number)		4b. City, Town, or L	ocation of Death	1	4c. County of D	eath
			Anne Arundel Medical			Annapol:		1	Anne A	
О	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bit	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day SEP 22,	7, Year) 9.1 1020 N.	Birthplace (State or Foreign Country)
	Director		135-30-5256 The State of Decedent	66				SEP ZZ,	1930	ew Jersey
	land ow		10a. State 10b. County	10c. City, Tow	vn or Lo	cation				10d. Inside City Limits
	Man,	tor	Maryland N/A			Balti	more			1 X Yes 2 □ No
	n the	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	th wil	aiD	1423 Elmtree Street			21226			USA	
	within 72 hours after death with the Maryland ene. Than "netural", or items 23a or 28a-f show he Medical Evarili at must be notified at	Funeral Director	Arm	Decedent Ever in U.S. ed Forces?	13. V	Vas Decedent of Hisp Yes, specify Cuban,	panic Origin? (S , Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
36	or It		1 Never Married 2 Married 1 If Ye	Yes 2 X No s, Give	i		Specify:		Specify:	Thito
21215-0036	hour tural	Completed by	3 ☐ Widowed 4 ☑ Divorced Yea 15. Decedent's Education	r or Dates:	Deced	lent's Usual Occupati	ion		16b. Kind of Busine	White
15	in 72	olete	(Specify only highest grade comple	eted)	(Give	kind of work done du DO NOT use retired)	ring most of wor	king		·
72	with liene.	шо	Elementary/Secondary (0-12) Colle	ege (1-4or 5+)	Hom	nemaker			Own Home	9
ğ	e filec I Hyg othe /ent,	Be C	17. Father's Name (First, Middle, Last)				8. Mother's Nan	ne (First, Middle,	Maiden Sumame)	
<u>Ilar</u>	uld by Menta Irked Itic e	ToE	Clarence Clayton Spe	eck			Ruth	Phyllis	s UNK	•
Maryland	and h		19a. Informant's Name/Relationship (Type, Prin	198					r, City or Town, State	a, Zip Code)
≥,	and sealth		Elizabeth D. Fowler/D			Hardwood	Trails	Rustbur		588
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Hygiene 21 is marked other than "netural," or Items 23a or 28a-f show eny injury or other treumetic event, the Medical Ever it at must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal	comete	ery, cren	sition (Name of natory or other place))	Date	20c. Location - City	or Fown, State
tim	tent:	. 77	1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)			matory, Ir		05	Baltimor	e, MD
Bal	Depar Depar Impor eny in		21. Signafile of Funeral Service dicensee Edward A. Gregorch:			. Name and Address emation S		of MD, I	nc.	
	42204		23a. Part1. Enter the disease, or complications		not ente	99 Frederi	ck Road	Baltimo	nc. re, MD 21	228 Approximate
١,			shock, or heart failure. List only one cause	on each line.						Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) a.	ue to (or as a consequence	>V	eck				
В	Examiner			De PAC ue to (or as a consequence Per in eq	m.	ric Ab	SCLS	5		
	1100	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	dineuparnon a na no) of el	HORF:					
	be executed sician and burial-transit	Examiner	that initiated events C.	Puplone		witis				
760,	e exe ian a urial-l		resulting in death) Last	ue to (or a consequence	of):					
876	e % e	dical	d						·	-
89 X	The taw requires that the death certificate to the tas been signed by the attending physicage 2 should be detached for use as the table.	Physician/Med	IF FEMALE: 23c. If ye	s, outcome of pregnancy			0.0		23d. Date of	deliven
Вох	atten for u	clan	in the past 12 months?	Live birth 2 Fetal death		Ectopic pregnancy Other (specify)			Month	Day Year
Ö.	at the de by the a stached t	nysi	1 Yes 2 Wo 9	Unknown						
٣,	s that med t	by P	Part II. Other significant conditions contributing	to death but not resulting	in the ur	nderlying cause given	in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	w requires been sign should be		End Stage K	ened Vi	Sa	se_		1 🗆 Y	es 2□No 3□	Probably 4 Unknown
Records,	e taw requ has been je 2 shoul	ompleted	Thrombocyto	perio				24a. Was a	sv 🚽 prior	autopsy findings available to completion of cause of
Ä		Сош	1					perfor 1 ☐ Yes		?
Vital	Physician: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?					th (Check only or	ne)	
of \	Physic this c	우	1 Yes 2 Hospital:	1 □ patient 2 □ ER/O			4 LI Nuising I		ence 6 Other (S	pecify)
	ing After une	ion	1 atural 5 Pending		Time of Injury	Work?	at es 2 □ No	28d. Describe n	ow injury occurred	
isio	Attending ir death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	Place of Injury - At home, f	arm str		3 2 110	28f. Location (S	itreet and Number or	Rural Route Number,
Division	or after or in or	ertification:	4 Homicide determined 256.	building, etc. (Specify)		oot, ractory, other		City or Tow		,
	urs are	O	29a. Certifier 1 Certifying Physician:	To the best of my knowledg	ge, death	occurred at the time	, date and place	, and due to the o	ause(s) and manner	as stated.
	B Ho B Fu Betely	edical	(Check only 2 Medical Examiner: On one)	the basis of examination a manner stated.	nd/or inv	estigation, in my opir	nion, death occu	rred at the time, o	date and place, and o	lue to the cause(s)
		_	29b. Signature and title of certifier			29c. License	number	4	29d. Date signed (Mo	opth, Day, Year)
	To the Hosp within 24 ho To the Fund completely f	Σ)	0		- C-	97	7/1/2/	
)	To th withir To th	2	AM	- IV	7	1000	0500	- 11	-101	65
)	To the within To the Comp	×	30. Name and address of person who completes	cause of death (Item 23a)		Print)	1, 6	+ 12	1 1	1 - MO 22/15
)	\	<	HaviArzo Youra	m9 6	(Type,	Print)	Ave S.	-tt= 12	(Amap	165 MD Zi401
8.	Sta Registr	te	HawArzh Youwa 31. Date filed (Month, Day, Year)	d cause of death (Item 23a)		Print)	Ave S	-11-12	(Araap	165 MD 21401
DH	Sta	ate rar	HaviArzp Yourc 31. Date filed (Month, Day, Year)	m9 6		Print)	Ave S	-11 /2	(Anage	165 MD Zi 401

			1 - State Registrar	State of Mar		artment of F rtificate of			ene 2,005 (3636
			Decedent's Name (First, Middle, L.)	ast)		711110010 01	200	2. Date of Death	1	3. Time of Death
	Physici /Medic		Leurine				Davis	-Month	Day Year	2346PM
	Examin		4a. Facility Name (If not institution, g		,	-	or Location of Death	1	4c. County of Death	
	Funeral	ō			In yrs. last birthday		If Under 24 Hrs.	8. Date of Birth		place (State or Foreign
	Funeral Director		217-20-7566	1□M 2□XF 93		Months Days	Hours Min.	8. Date of Birth (Month, Day, 1–10–1)		Va.
	and w		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryla	tor	Md. NA			imore				1X Yes 2 No
	r 28a	Director	10e. Street and Number			10f. Zip Code	2	10	g. Citizen of What Cou	intry?
	236 o 236 o ust by	raiD	3418 Erdman Ave	· •		2121	.3		USA	
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "naturel", or items 23c or 28a-f show event, the Modical Exemplent in all be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🕱 No	Hispanic Origin? (S) an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: R	
21215-0036	2 hour	ted b	15. Decedent's	Year or Dates: Education	16a. Dece	dent's Usual Occup	pation	1	6b. Kind of Business/li	
215	- 10	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wor.	king		
	filed wil Hygien other th	Con	12th grade		La	borer			Bugle's L	aundry
Maryland	should be filed withir de Mental Hygiene. marked other then metic event, Ite M.	Be c	17. Father's Name (First, Middle, La James V	Malker	Haski	ns	Mary	ne (First, Middle, M Eli	zabeth	Turner
ary I	should and Men s marke	Ţ	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, State, Zi	p Code)
	27 Tr		Yvonne Brown	Daughter	7-1	8 Erdman	Ave. Ba	ltimore,	Md. 21213	<u>, </u>
Baltimore,	m 0		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	☐Removal from State		matory or other pla	· 1		Oc. Location - City or T	
<u>=</u>	2 5 2 5		*4 □Donation 5 □ Other (Special Service Lice)			lem. Park 2. Name and Addre	2-9		Randallst	
Ba	Depare Importanting		> Glady	Wanes		March F.	H. East	1101 E	. North Av	21202 e.
M			23a. Part1. Enter the disease, %r co shock, or heart failure. List on	mplications that caused the ly one cause on each line.				-		Approximate Interval Between Onset and Death
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)		consequence of):	ARCINO	HA OF	URIWARY	BLADDER	2 Woully
	Examiner			b. Due to (or as a	5714	12 Rang	16 Direa	ee + Dia	Lysis 2	44
	p ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		consequence of):		1		1	
	xecute and II-trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a	onsequence of):) + PP/L	LEX Cy		2	41.
38760,	icate be executed physician and s the burial-transit	cal E			Efsis				1	week
~		Aedicai	IE EENALE							
.O. Box	that the death certific ed by the attending F detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of deliv Month	very Day Year
S, D	law requires that the as been signed by th 2 should be detache	by Pi	Part II. Other significant conditions	contributing to death but	not resulting in the u	inderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ecords,	v require been si should b							1 🗆 Yes	2 □ No 3 □ Pro	babły 4 AUnknown
\mathbf{x}	The ate ha	Completed			-			24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of 2 No
Vital	Physicien: Th r this certificate ral director, paq	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{X} \) No	Hospital:	2 🔀 ER/Outpatie	2 DOA O#	205	th (Check only one		_
of			27. Manner of Death	1 Inpatient 28a. Date of Injury (Month, Day)	28b. Time o	IL SU DOA	4 Nursing n	28d. Describe hov	ice 6 Other (Speci v injury occurred	<i>Ŋ</i>)
sior	Attending I r death. sctor: After by the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	on	/ear) Injury		Yes 2□No			
Division		ertification;	3 Surcide 6 Could not determine	28e. Place of Injury building, etc.	· At home, farm, st (Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
	Hospite 4 hours Funerel ely fille	Medical C	29a. Certifier (Check only one) 1 Certifying 1 2 Medical Ex	Physician: To the best of aminer: On the basis of earth manner state	xamination and/or in	h occurred at the till vestigation, in my o	me, date and place opinion, death occur	, and due to the cau rred at the time, dat	use(s) and manner as s te and place, and due t	stated. to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier			29c. Licens		290	d. Date signed (Month,	,
,	1/2	-			Dan		1422/		2.7.0)
2	16		30. Name and address of person wh				a Rivel	Rallia	766 2200	1 21721
*	Sta		31. Date filed Month, Day, Year)	32. Registrar's	s Signature	Eusie"	II OIVA	Dan	1016 1011	1 21 22
	Registr	ar	FEE	32. Registrar	Eleve 1	& Span	W			

Ġ.			For State Registrar	State of Mai		artment of H rtificate of L		lental Hygiq	2005	03637
	Physici /Medic		Decedent's Name (First, Middle, Last Verni		Down	ing		2. Date of Death Month February	^{Day} , 2005	3. Time of Death 11:37 A M
	Examin		4a. Facility Name (If not institution, give Johns Hopkins Hosp	,		4b. City, Town, or Baltimor	Location of Death		4c. County of Deat	th
	Funeral Director			7. Age	(In yrs. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) 7-29-4	rear) Co	hplace (State or Foreign buntry) N.C.
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County Md. Harfor		10c. City, Town or Lo					10d. Inside City Limits X☐ Yes 2☐ No
	h with the f 3a or 28e- at be notif	Funeral Director	10e. Street and Number 822 Mt. Vernon C		Lage	10f. Zip Code 2104	0	100	g. Citizen of What Co	puntry?
036	be filed within 72 hours after death with the Maryland ital Hygiene. Ind other than "natural", or Items 23a or 28e-f show event, the Medical Examinar must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Amed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 🎇 No	ispanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
Maryland 21215-0036	within 72 ho ene. than "natur the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 10th grade		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of worki)	ng	Social Social	Industry
and 2	d be filed within nial Hygiene. ed other than 's event, the Me	Be	17. Father's Name (First, Middle, Last) Freeman	Sn	encer	sereeping	18. Mother's Name		viden Sumame)	
lary	s 1 and 2 should be f Health and Mental Item 27 is marked other traumatic ev	T	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir		and Number or Rura		Borrov City or Town, State, 2	Zip Code)
	ages 1 and nt of Health :: If Item 27	1000	William Downing 20a. Method of Disposition 1 Sk Burial 2 Cremation 3 F	Husband lemoval from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place	e)	Date 20	oc. Location - City or	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other <u>9008</u> .		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	Few States	22	armel Cem Name and Addres March F.H	ss of Facility	Baltim	Dundalk, M ore, Md. North Ave	21202
	Physician		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition	1		er the mode of dying	g, such as cardiac o	r respiratory arres		Approximate Interval Between Onset and Death
68760,	Medical Examiner be executed by physician and burial-transit sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Lines underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of): consequence of): consequence of):					
P.O. Box 68	ath certifi ttending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□Unknown	☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions con						cco use contribute to	the cause of death?
Il Records,		Completed	PULMONARY	SACCIDIS	15			24a. Was an autopsy performe	prior to c	topsy findings available completion of cause of
Vital	yaician: The is certificate hi director, page	Be	25. Was case referred to medical examiner?	lospital:		015	26. Place of Death	(Check only one)		
o		atlon; To	27. Manner of Death 1 X Yes 2 No 27. Manner of Death 2 No 27. Manner of Death 1 X Natural 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day)	2 ☐ ER/Outpatien 28b. Time of Injury	28c. Injury Work	4 INDISHING FIOR	ne 5 Residence 28d. Describe how	ce 6 □Other (Specinjury occurred	rify)
Division	in Director	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	/ - At home, farm, str (Specify)	eet, factory, office	2	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	the Hospital hin 24 hours the Funeral npletely filled	edical	29a. Certifier 1 Certifying Physical Check only one) 1 Certifying Physical Exami	sician: To the best of ner: On the basis of a and manner state	Ramination and/or inv	occurred at the tim restigation, in my op	e, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
)	To the within: To the comple	Me	29b. Signature and title of certifier		~	29c. License	c.M.E.		Date signed (Month February 5	
4	10		30. Name and address of person who co	CIRPLS	th (Hem 23a) (Type,	Print) 111 Penn S	Street, B	altimore	, Maryland	21201
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registar	s Signature	Special				

Box 68760, P.0. Records, Vital Division

State Registrar

Physician

/Medical

Examiner

Funeral

Director

or than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at

72 hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: filem 27 is marked other than any injury or other traumath.

Physician

/Medical

Examiner

burial-transit

as the t

for use

detached ģ signed t d be deta

page 2

funeral director,

the

filled in by

this certificate

After

death.

hours after ö

To the Hospital

within 24 hours after death To the Funeral Director:

the attending physician

be executed

5-0036

2121

Maryland

Baltimore,

Direct

by Funeral

Completed

Be

Examiner

Physiclan/Medical

ģ

Completed

Be

Certification: To

DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year) FEB 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

TIMONIUM, MD 21093

			1 - For State Registrar	State o	f Maryland		artment of F		nd Menta	al Hygie	71115	03639
I	Physici	an	1. Decedent's Name (First, Middle, L	•						ite of Death	Day Year	3. Time of Death
	/Medic	al	Dorothy S. D		F - J					ruary	3, 2005	6:15 A ^M
	Examin	er	4a. Facility Name (If not institution, gr		mber)		4b. City, Town, o		Death		4c. County of Dea	
	Funeral		Suburban Hospi 5. Social Security Number 6.	Sex	7. Age (In yrs. la	st birthday)	Bethes If Under 1 Year	If Under 2	24 Hrs. 8. Da	te of Birth onth, Day, Ye	Montgom 9. Bin	hplace (State or Foreign
	Director		217-32-4378	1□M 2⊠F	69	Yrs.	Months Days	Hours	Min. (M Sept	o <i>nth, Day, Ye</i> e mber 2	ear) 4, 1935 M	ountry) arvland
	pur *		Usual Residence of Decedent 10a, State 10b, County		10c City	Town or Lo	cation					10d. Inside City Limits
	Maryli f sho	ō	D.C			Washi						1 Yes 2 No
	1 the 1	Director	10e. Street and Number				10f. Zip Code			10g	. Citizen of What Co	ountry?
	th with		4104 Garrison	Street,	N.W.		20016-	-4224		U	nited Sta	ites
	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "netural", or Items 23a or 28e-f show avant, Ite Madical Examinet must be nutilied at	Funeral	11. Marital Status	Armed Fo		i. 13. \	Was Decedent of H	lispanic Orig	in? (Specify Your Puerto Rican,	es or No- etc.)	14. Race - Ame Black, Whit	
50	rs afte	by Fı	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Gir Year or D	ve		1⊡Yes 21X No	Specify:				nite
212-0030	2 hou	ted t	15. Decedent's B	ducation	74165.	16a. Deced	ient's Usual Occup	ation		16	b. Kind of Business	
2	oe filed within 72 h al Hygiene, d other than "netu want, ir e Mode	Completed	(Specify only highest g	rade completed) College (1-4or 5+)	(Give life. L	kind of work done of OO NOT use retired	during most d)	of working			,
Z	ed wit	Con	12			S	ecretary				Accountir	ng Firm
land	be fith	Be	17. Father's Name (First, Middle, Las Thomas J.J. Smooth	•					's Name <i>(Fir</i> st en Neu		iden Sumame)	
Ĕ	2 should be f and Mental F is marked of raumatic ava	2	19a. Informant's Name/Relationship			19h Mailin	ng Address (Street				ity or Town, State, 2	Zin Cada)
Z Z	nd 2 s lith an 27 is r trau		Robert Franklin		ı						Maryland	
ē,	is 1 ai of Hea ltem othe	1 8	20a. Method of Disposition		1 00	ice of Dispo	sition (Name of natory or other place	e) IT.	Date	200	c. Location - City or	Town, State
aitimore,	Page nent c ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec		State	•	rk Cemete		2005	В.	altimore,	Maryland
Ball	permit. Pages 1 and 2 should be Department of Health and Menta Important: If tlem 27 is marked any Injury or other traumatic a <u>once</u> .		21. Signature of Funeral Service Lice	nsee	M01420	Roj 75	Name and Address bert A. Pun	ss of Facility phrey I		Home/Bet	thesda-Chevy	Chase, Inc. 4-3501
n	===		23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that	aused the death.							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	F	3 0011	lyr	mohar	na			:	Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conseque	ence of):	. 751101	110				@ mom_3
	LAGIIIIICI	er	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a conseque	ance of):						
	nted I Insit		Cause. Enter Underlying Cause (Disease or injury	200 10	(or as a conseque	31100 01/.						
<u> </u>	execu an and rial-tra	Examin	that initiated events resulting in death) Last	c. Due to	(or as a conseque	ence of):						
8/6U	icate be executed physician and s the burial-transit	ical		d								revie:
٥	ertifica ling ph e as t	Medi	IF FEMALE:									
X P	the death certifi y the attending iched for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	tcome of pregnan pirth 2 Fetal on ant at time of dea	death 3□	Ectopic pregnancy	,			23d. Date of del	ivery Day Year
o.	the de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unkn		atri 5	Other (specify)					
ري ح	The law requires that the death certifi ste has been signed by the attending tage 2 should be detached for use as	by Pł	Part II. Dther significant conditions	contributing to d	eath but not resul	ting in the ur	nderlying cause giv	en in Part I.	23	3e. Did tobac	co use contribute to	the cause of death?
Hecords,	equire en sig ould b									1 ☐ Yes	2□No 3□Pr	obably 4 Dunknown
င္ပ	2 8 6	Completed							24	a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
r =		Con							1[performed ☐ Yes 2 🕡	d? death?	200 NO
VII	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	_		04		of Death Chec			
Ö	Phys this aldi	- To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date		R/Outpatien 28b. Time of	t 3 DOA Oth	4 🗀 1401	-		e 6 Other (Specinjury occurred	cify)
0	th. th. : After this funeral	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigati	(Mon	th, Day Year)	Injury	Worl	k? , _	_	030110011011	injury occurred	
DIVISION	Attander death	ertification;	3 Suicide 6 Could not determine	200. Flace	of Injury - At honing, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Lo	cation (Stree	at and Number or Ru	ıral Route Number,
5	tal or rs afte al Dir ed in	O		Dulid	ing, etc. (Specify)					ty or Town, S	naie)	i
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying F (Check only one) 1 Medical Exe	eminer: On the b	e best of my know asis of examinationer stated.	ledge, death on and/or inv	occurred at the tin restigation, in my o	ne, date and pinion, death	place, and du n occurred at th	e to the caus ne time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	Ton			29c. Licens				Date signed (Monti	
			> YICKON	lmD			DC	0061	631	ć	2-3-0)5
1	H		30. Name and address of person who					n -				
	1,		Natasha Chen, M. I 31. Date filed (Month, Day, Year)	9901	Medical	Cente:	r Drive,	Kockv:	ılle, M	larylar	nd 20850	
ř.	Sta Registr			2005	legistrar's Signatu	7. Sp	roll					

CPM 05-00875 Rebecca Donaway

DHMH 17 Rev 1/2001

n il		D - 1 - T	- D				Month	D	ay)	ear.	
		Rebecca Lyni	n Donav				Febru	ary	03, 20		08:48 A M
r '	4a. Facility Name <i>(If not institution, give</i> s Carroll Hospital C			4b. City		r Location of Dea tminstel		4	c. County of Carro		
	5. Social Security Number 6. Sex 215-37-5180	7. Age (In yrs) If Und Months	or 1 Year Days	If Under 24 Hr Hours Mir		jirth 29,	1992	Birthp Coun Mar	lace (State or Foreigr try) yland
	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or L	ocation						1	0d. Inside City Limits
.	Maryland Carroll			stmin	eter						1 ☐ Yes 2 ☒ No
ပ္က 📙	10e. Street and Number				ip Code			10g. C	Citizen of Wh	at Coun	try?
e D	490 Pinehurst Circ	cle			21	158		Un	ited S	Stat	es
	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	J.S. 13.				Specify Yes or hero Rican, etc.)	10-	Black,	White,	etc.
og pa		Year or Dates:	1 40- 0					101			
) ete	(Specify only highest grade	completed)	(Give	e kind of w	ork done	during most of w	orking	16b.	Kind of Busi	ness/inc	lustry
E	Elementary/Secondary (0-12)	College (1-4or 5+)	Stude	ent				Ed	ucatio	n	
Be C	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Midd	le, Maide	en Sumame))	
0											
- 11-		20b.	Place of Disp	osition /N	ame of	1	Date	-			
	1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State Ga	cemetery, cre ale of	matory or Heav	other plac en	^{⊛)} Febr	ruary 8,				
-		6			and Addre	ss of Facility	-003				
	1 Roy Dark	MO($0198^{+0.000}_{-0.000}$	obert 57 wi	: A. scons	Pumphrey sin Ave.	/ Funera . Bethes	l Ho da.	me/ c MD 208	hase	e. Inc. 3501
	23a. Part1. Ent. The disease, or complication shock, or heart failure. List only on	cations that caused the dea									Approximate Interval Between
	Immediate Cause (Final disease or condition	Bupropion i	ntoxica	ation							Onset and Death
	resulting in death)										
	Sequentially list conditions,	Due to (or as a conse	guence of):							-	
Ĕ	cause. Enter Underlying Cause to issue or injury		,							- 9	
Ä	resulting in death) Last	Due to (or as a conse	quence of):				· · · · · · · · · · · · · · · · · · ·				<u> </u>
cai	d										
Med	IF FEMALE:)- If sub of			-						
lan/	in the past 12 months?	1 Live birth 2 Fe	al death 3			/		1			ry Day Year
ysk	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown		Smer (poury)_						
by Ph	Part II. Other significant conditions con	tributing to death but not re	sulting in the	underlying	cause giv	en in Part I.	23e. Dic	tobacco	use contrib	ute to th	e cause of death?
							10] Yes	2□No 3	☐ Prob	ably 4 Unknown
piet									24b. We	ere autor	osy findings available
E 0							per	formed?	de	ath?	2□ No
Be	25. Was case referred to medical examiner?	a anitat.			0#		eath (Check only	one)			
0	IA Tes 2 No	1 □ Inpatient 2 L	1		OA	4 🗆 IAUISING					
tion	1 □Natural 5 □ Pending	Foundh, Day Year)	Found	• M	Wor	k?	Zod. Describe	a now in	jury occurred	2	unk
fica	3 Suicide 6 Could not be	28e. Place of Injury - At	home, farm, si	A		X	28f. Location	(Street	and Number	or Rura	Route Number
ert	4 Homicide	building, etc. (Spec	ify)		,						
edicai	29a. Certifier 1 Certifying Phys	ician: To the best of my kr er: On the basis of examin	nowledge, dea nation and/or in	th occurre	d at the tir	ne, date and place opinion, death oc		-	/ - \		
Med		and manner stated.									
		ah Ali-									•
			m 23a) (Tvne	, Print)				10	~_ au_ y	0-1	, 2007
Medical Certification: To Be Completed by Physician/Medical Examiner	Metica Certification: 10 be Compresed by Thysician Practice in The Compresed by Landing	11. Marital Status 12. Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade) Elementary/Secondary (0-12) 6 17. Father's Name (First, Middle, Last) Michael M. Donaway 19a. Informant's Name/Relationship (Type) Michael M. Donaway 20a. Method of Disposition 1 Burial 2 Cremation 3 Recomplied to the property of the property	11. Marital Status	11. Marital Status 12. Was Decedant Ever in U.S. Amed Forces? 13. Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Education (Specify only highest grade completed) 17. Father's Name (First, Middle, Last) Michael M. Donaway 19a. Informant's Name/Relationship (Type, Print) Michael M. Donaway/Father 20a. Method of Disposition 1	11. Marial Status 12. Was Decedent Ever in U.S. 13. Was Decedent Status 15. Decedents Education (Specify only highest grade completed) 16. Decedents Education (Specify only highest grade completed) 17. Father's Name (First, Middle, Last) Michael M. Donaway 19a. Informant's Name/Relationship (Type, Print) Michael M. Donaway/Father 20a. Method of Disposition 1 Status 21. Signature of Funeral Service (Licensee Moonation 5 Cheer (Specify) 21. Signature of Funeral Service (Licensee Moonation 5 Cheer (Specify) 223a. Partl. Ent. Fine disease, or complications that caused the death. Do not enter the microsulting in death) Last 1 Immediate Cause (Final disease). The part is disease or complications that caused the death. Do not enter the microsulting in death) Last 1 Immediate Cause (Final disease). The part is disease or complications that caused the death. Do not enter the microsulting in death) Last 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Passic Licensee 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Passic Licensee 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (License). The past 12 months? 1 Yes Yes	11. Marrial Status 12. Never Married 12. Mas Decedent Ever in U.S. Amad Forces? 12. Never Married 13. Was Decedent Ever in U.S. Amad Forces? 14. Never Married 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Education (Specify only highest grade completed) 17. Father's Name (First, Middle, Last) 19. Michael M. Donaway 19. Informant's Name/Relationship (Type, Print) 19. Mailing Address (Street 10. Place of Disposition 16. Burnal 2 Cremation 3 Removal from State 16. Burnal 2 Cremation 3 Removal from State 16. Decedent's Education 16. Burnal 2 Cremation 3 Removal from State 16. Decedent's Education 16. Burnal 2 Cremation 3 Removal from State 16. December, groups of other place 17. Signature of Fundar Service Licensee 18. Mool 19. Pince of Disposition (Name of Cameter, groups of other place 19. Place of Disposition (Name of Cameter, groups of other place 19. Place of Disposition (Name of Cameter, groups of other place 19. Place of Disposition (Name of Cameter) 19. Mailing Address (Street 19. Place of Disposition (Name of Cameter) 19. Mailing Address (Street 19. Place of Disposition (Name of Cameter) 19. Mailing Address (Street 19. Place of Disposition (Name of Cameter) 19. Place of Di	11. Marial Status 12. Was Decedent Ever in U.S. Amed Forces? 17. Was Decedent of Hispanic Origin? 17. Was Specify Cuban, Mexican, Put 17. Was 282No 17. Was Specify Cuban, Mexican, Put 17. Was 282No 17. Was Specify Cuban, Mexican, Put 17. Was 282No 17. Was Specify Cuban, Mexican, Put 17. Was 282No 17. Was Specify: 18. Marian 17. Was 282No 17. Was Specify: 18. Marian 17. Was 282No 17. Was Specify: 18. Marian 18. M	11. Mars I Stallus 12. Was Decodent Ever in U.S. 13. Was Decodent of Hispanic Origin? (Specify Yes or Named Forces?) 12. Was Decodent of Hispanic Origin? (Specify Yes or Named Forces?) 12. Was Decodent of Hispanic Origin? (Specify Yes or Named Forces?) 12. Was Decodent of Hispanic Origin? (Specify Yes or Named Forces?) 12. Was Decodent of Hispanic Origin? (Specify Yes or Named Forces?) 12. Was Decodent of Hispanic Origin? (Specify Yes or Named Forces?) 12. Was Decodent of Hispanic Origin? (Specify Yes or Named Forces?) 12. Was Decodent of Hispanic Origin? (Specify Yes or Named Forces?) 12. Was Decodent of Hispanic Origin? (Specify Yes or Named Forces?) 12. Was Decodent of Hispanic Origin? (Specify Yes or Named Forces?) 12. Was Decodent of Hispanic Origin? (Specify Yes or Named Forces?) 12. Was Decodent of Hispanic Origin? (Specify Yes or Named Forces?) 12. Was Decodent of Hispanic Origin? (Specify Yes or Named Forces?) 12. Manual Occupation of Manual	11. Marial Status 12. Was Decodent Ever in U.S. 13. Was Decodent of Hispanic Origin' (Specify Yes or Normal Armod Forces') 14. Marial Status 15. Never Married Married 15. Decodent's Education 15. Decodent's Education 15. Decodent's Education 16. Specify only ingriest grade combined 16. Specify only ingr	13. Marial Satis 2. Was Dependent Ever in U.S. 13. Was Dependent Ever in U.S. 13. Was Dependent of Hispanic Origin? (Speedy Yes or No- III Head States 13. Was Dependent of Hispanic Origin? (Speedy Yes or No- III Head States 13. Was Dependent of Hispanic Origin? (Speedy Yes or No- III Head States 13. Was Dependent of Hispanic Origin? (Speedy Yes or No- III Head States 13. Was Dependent of Hispanic Origin? (Speedy Yes or No- III Head States 14. Race- 14. Race- 15. Dependent of Use of Dependent of Use	11.1 Martial Status 12.2 Was Dependent Ever in U.S. 13.1 Was Dependent of Histogenic Origin? (Specify, Yes on No. 14 Race - Americal 1.2 Was Dependent of Histogenic Origin? (Specify, Yes on No. 14 Race - Americal 1.2 Was Dependent of Histogenic Origin? (Specify, Yes on No. 14 Race - Americal 1.2 Was Dependent of Histogenic Origin? (Specify, Yes on No. 14 Race - Americal 1.2 Was Dependent of Histogenic Origin? (Specify, Yes on No. 14 Race - Americal 1.2 Was Dependent of Histogenic Origin? (Specify, Yes on No. 14 Race - Americal 1.2 Was Dependent of Histogenic Origin? (Specify, Yes on No. 14 Race - Americal 1.2 Was Dependent of Histogenic Origin? (Specify, Yes on No. 14 Race - Americal 1.2 Was Dependent of Histogenic Origin? (Specify, Yes on No. 14 Race - Americal 1.2 Was Dependent of Histogenic Origin? (Specify, Yes on No. 14 Race - Americal 1.2 Was Dependent of Histogenic Origin? (Specify, Yes on No. 14 Race - Americal 1.2 Was Dependent of Histogenic Origin? (Specify, Yes on No. 14 Race - Americal 1.2 Was Dependent of Histogenic Origin? (Specify, Yes on No. 14 Race - Americal 14 Was Dependent of Histogenic Origin? (Specify, Yes on No. 14 Race - Americal 16 Was Dependent of Working 16 Was Depende

Baltimore, Maryland 21215-0036

	1 - For State Registrar		State of	Marylan		artment of rtificate o	Health and of Death	Mental H	ygiene Reg. No	711115	03641	
	Decedent's Nam	e (First, Middle, I	Last)					2. Date of D	eath		3. Time of Death	
ian ical	Virgie F	rances D	avis					Month Februa	Da arv	y Year 5, 2005	11:45 PM	1
ner			give street and numb	oer)		4b. City, Town	n, or Location of De			County of Dea		_
Ш			rsing Cen				Baltimo		Ва	altimor	e City	
	5. Social Security N 230-10-6 Usual Residence of	182	Sex 7.	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Ye Months Day			Day, Year)	C	rthplace (State or Foreig ountry)	n
	10a. State	10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits	-
ţ	MD	Baltim	ore City	Bal	timore	.					1 ☑ Yes 2 ☐ No)
Director	10e. Street and Nu		010 010,	Dul	CIMOIC	10f. Zip Cod	9		10g. Cit	tizen of What C	ountry?	
	1002 High	net Way				21206			USA			
Funeral	11. Marital Status	ice nay	12. Was Decede			Was Decedent of	of Hispanic Origin?	Specify Yes or N		14. Race - Am		
b	1 ☐ Never Marr 3 ☑ Widowed	ed 2 Married 4 Divorced		No		TYes, specify C	uban, Mexican, Pue lo <i>Specify:</i>	erto Rican, etc.)		Black, Whi		
Completed	(Sner	15. Decedent's	Education grade completed)			dent's Usual Occ		- 400	16b. K	ind of Business		-
nple	Elementary/Seco		College (1-4	or 5+)	life.	DO NOT use ret	ne during most of w ired)	orking	Ele	ctronic	:s	
Son	12		18 11		Facto	ry Work	er					
Be	17. Father's Name	First, Middle, La	st)				18. Mother's Na	ame (First, Middl	e, Maiden	Sumame)		
2	Roy Radf	ord Feat	her				Lula Ar	n Harris	on			
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Street and Num										Zip Code)	
	Carolyn 1	Welka/Da	ughter		3713	Frankfo	ord Avenu	e Baltim	ore,	MD 212	06	
	20a. Method of Disp		☐Removal from St		ace of Dispo	sition (Name of natory or other p	place)	Date	20c. Lo	ocation - City or	Town, State	
١.	`4 □Donation			119	-	of Faith	t t	Feb 8 2005	Balt	timore,	Maryland	
	21. Signature of Fu	neral Service Lic	ensee	800L	. 22	. Name and Add	dress of Facility				-	
	12	Mu	- L	400401	, .	remation	and Funer	ral Alter	nativ	ves		
	23a. Part1. Enter the	ne disease, or co	mplications that cau by one cause on eac	sed the death	. Do not enti	er the mode of o	lying, such as cardi	ac or respiratory	arrest,	more, M	Approximate	
	Immediate Cause	Final	-								Interval Between Onset and Death	
	disease or condition resulting in death)	n		RA TUE as a consequ							I WEST	
			CIRINA		RACT	INFEE					1 WEEK	
ē	Sequentially list con any leading to in cause. Enter Unde	nditions,	U.	as a consulti	enta of)	1410	1700				1 3000	
aminer	Cause (Disease or	injury										
Еха	that initiated events resulting in death) i		Due to (or	as a consequ	ence of):		-					-
ğ			0				-					
	IF FEMALE:	pregnant	23c. If yes, outco	2 Fetal	death 3	Ectopic pregnar Other (specify)			2	23d. Date of del Month	livery Day Year	
ysician/Medical	in the past 12 1 Yes 25 9 Unknown	months?	4□Pregnan 9□ Unknow									
Physici	in the past 12 1 ☐ Yes 2 € 9 ☐ Unknown	months?	9□ Unknow	n	Iting in the ur	dorlying on to	grups in Bort I	220 Did	tobooo	an nontribute to	the severe of death?	
by Physici	in the past 12 1 Yes 25 9 Unknown	months?	9□ Unknow	h but not resul	lting in the ur	nderlying cause	given in Part I.				the cause of death?	
by Physici	in the past 12 1 ☐ Yes 2 € 9 ☐ Unknown	months?	9□ Unknow	h but not resul	Iting in the ur	nderlying cause	given in Part I.		tobacco u Yes 2-		o the cause of death? robably 4 □Unknown	
ompleted by Physici	in the past 12 1 Yes 25 9 Unknown	months?	9□ Unknow	h but not resul	Iting in the ur	nderlying cause	gwen in Part I.	1	Yes 2-6	No 3 Pr	topsy findings available	
e Completed by Physici	in the past 12 1 Yes 2E 9 Unknown Part II. Dther signif	icant conditions	9□ Unknow	h but not resul	Iting in the ur	nderlying cause		1	Yes 2-	No 3 Pr	robably 4 Unknown	
o Be Completed by Physici	in the past 12 1 Yes 25 9 Unknown	icant conditions	9 Unknow	n h but not resul			26. Place of De	24a. Was auto perf 1 Yes	Yes 26 an psy ormed? 2 No one)	24b. Were at prior to death?	robably 4 Unknown utopsy findings available completion of cause of 2 No	
Be Completed by Physici	in the past 12 1 Yes 24 9 Unknown Part II. Other signif ALZ HEIN 25. Was case referexaminer?	icant conditions	9 Unknow	n h but not resul		t 3□ DOA C	26. Place of De Other: 4⊜Nursing	1	Yes 2-	24b. Were au prior to death? 1 Yes	robably 4 Unknown utopsy findings available completion of cause of 2 No	

Division of Vital Records, P.O. Box 68760, To the Hospital or Attanding Physician: The law within 24 hours after death.

To the Funaral Director: After this certificate has b completely filled in by the funeral director, page 2 st Medical Certific

3 🗌 Suicide 4 Homicide 29a. Certifier (Check only one)

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

21239

MD

29b. Signature and title of certifier

29c. License number Da 8987 29d. Date signed (Month, Day, Year) 2-6-2005

30. Name and ad 7 ss of pers of o completed cause of death (Item 23a) (Type, Print)

CARL SPERLING, MD 31. Date filed (Month, Day, Year)

FEB 0 8 2005

560 Lecth RAVEN BLVD

32. Registar's Signature

3

Registrar

State

		-	State of Maryland / State of Maryland /	Department of Health and M Certificate of Death		ene 2005	03642
ı	Physicia /Medic	_	1. Decedent's Name (First, Middle, Last) Eleanor F. Davidson		2. Date of Death February	^{Day} , 2005ar	3. Time of Death 5:10am м
	Examin		4a. Facility Name (If not institution, give street and number) Fairhaven Health Care Center	4b. City, Town, or Location of Death Sykesville		4c. County of Death Carroll	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 1 1 M 2 T F 84		8. Date of Birth (Month, Day, Y		place (State or Foreign ntry)
	laryland show	J.	Usual Residence of Decedent 10a. State 10b. County 10c. City, To MD Carroll	own or Location Eldersburg			10d. Inside City Limits 1 ☐ Yes 2X No
	or 28a-f	Director	10e. Street and Number	10f. Zip Code	10g	J. Citizen of What Cou	ntry?
	eath wi		1357 Walkabout Court 11. Marital Status 12. Was Decedent Ever in U.S.	21784	cify Yes or No-	USA 14. Race - Ameri	can Indian,
920	72 hours after death with the Maryland Inaturel', or Items 23e or 28e-1 show dreal Examiner must be neilified	by Funerai	Armed Forces? 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced Armed Forces? 1 □ Yes 2√3 No If Yes, Give A Year or Dates:	 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 ☐ No Specify: 	Rican, etc.)	Black, White,	etc. ite
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importants if item 27 is marked other then "naturel; or items 23e or 28a-f show any injury or other treumatic event, it is Micial Examiner must be mittled at once.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of workilife. DO NOT use retired)		Sb. Kind of Business/In	·
2	filed w Hygier other th	e Cor	17. Father's Name (First, Middle, Last)	Teacher 18. Mother's Name	(First, Middle, Ma	Education	
yland	2 should be f and Mental H Is marked of reumatic eve	To B	Robert Franklin Fleming		ence Brow		
, Mar	and 2 sho salth and n 27 Is m		Juliet C. Davidson (Daughter) 1		lersburg,	MD 21784	
altimore,	Pages 1 au nent of Hea ant: If item ury or othe		1 N Burial 2 Cremation 3 Hemoval from State	etery, crematory or other place)		eorgetown,	
Balt	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee Plange Haught Aerbert	fanchi funekāt home Sykesville, MD 21784			195)
	Physician		23a. Part1. Enter the disease, or complications that caused the death. It shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Do not enter the mode of dying, such as cardiac o	or respiratory arres		Approximate Interval Between Onset and Death Ne work
	/Medical Examiner		resulting in death) Due to (or as a consequent	ce of):			
	rcuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discass or Injury) that initiated events c.				
8760,	ate be executed obysician and the burial-transit	dical Ex	resulting in death) Last Due to (or as a consequent d	ce or):			
O. Box 6	death certific e attending p d for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 □Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
ds, P.	as tha	by	Part II. Other significant conditions contributing to death but not resulting COLOMARY AFTERY DISEASE	ng in the underlying cause given in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to	the cause of death?
Vital Records,	ne law require has been si ge 2 should b	Completed	atrial Fibrillation		24a. Was an autopsy performe	prior to co death?	opsy findings available ompletion of cause of
ta		Be Co	Congostive heart tailvre 25. Was case re erred to medical examiner?		1 Yes 2 € Check only one	Yes 1 Yes	2 No
of <	Physic this ce al direc	ို	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER	The second secon	me 5 Residen 28d. Describe how	ce 6 Other (Speci	fy)
lon	Attending Physicien: or death. ector: After this certific. by the funeral director,	ation	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury Work? M 1 □ Yes 2 □ No		,,	
Division of	는 다 H	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	a, farm, street, factory, office	28f. Location (Stre City or Town,	et and Number or Rur State)	al Route Number,
	To the Hospitel or Attenwihin 24 hours after death to the Funeral Director: completely filled in by the	edicai (29a. Certifier (Check only one) Certifying Physician: To the best of my knowle and manner stated.	dge, death occurred at the time, date and place, a and/or investigation, in my opinion, death occurr	and due to the cau ed at the time, dat	rse(s) and manner as a e and place, and due	stated. to the cause(s)
•	To the within To the comp	¥	29b. Signature and title of certifier	29c. License number	F FE	d. Date signed (Month,	7, 2005
	10		30 Name and address of person who completed cause of death (Item 23) AVA 5, Baket MD 7200 TAIN	3a) (Type, Print) A Avenue Sykesville	mD	21784	
	Sta Regist		31. Date filed (Month, Day, Year) FEB 0 8 2005	Sporte			

			1 - For State Registrar	State of Maryla			t of Health e <i>of Deati</i>		lental Hy	giene (05	03643
			Decedent's Name (First, Middle, Last)				2. Date			of Death		3. Time of Death
	Physici		LED 4 Devillages						Month 02	Day	Year .005	8.58am
	/Medi		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat					n of Death	02	4c. County		0 00
	Examir	ier	Good Samaritan	-		Baltimore				40. County	N/A	
			0	· · · · · · · · · · · · · · · · · · ·	s. last birthday)			er 24 Hrs.	8. Date of Bir	th.		lace (State or Foreign
	Funeral Director			1 M 2 □ F	Yrs.	Months	Days Hours		8. Date of Bir (Month, Da	y, Year)	Cour	MD
			Usual Residence of Decedent	8)			01 10 11/1			7112		
	land		10a. State 10b. County	10c. C	ity, Town or Lo	cation					1	Od. Inside City Limits
	Mary	ō	MD N/	4	T	Salti	more					1 X Yes 2 ☐ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28a-f show any injury or other traumatic event, it a Medical Evatures and the rotified at once.	ect	10e. Street and Number	·		10f. Zip	Code			10g. Citizen of \	Albat Cour	stor?
		۵	3911 Frankford Avenue			21214-				rog. Onizeri or	1194	iti y r
		Funeral Director		12. Was Decedent Ever in	110 121	Man Danne	and of Lineanic C	ye Vining (Con	of Versalle	14 Pag	000	an testina
		Į,	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	0.3.	f Yes, spec	dent of Hispanic C orly Cuban, Mexic	an, Puerto I	Rican, etc.)		e - Americ ck, White,	
36		by F	3 (Sa)Widowed 4 □ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes	2. ONO Specif	y:		Specify	13/1	7 CK
21215-0036		ed t	15. Decedent's E	1	16a Dagge	dont's Llaur	al Occupation			105 Kind of D		
5		Completed	(Specify onfy highest gr	ade completed)	(Give	kind of wor DO NOT us	rk done during mo	ost of working	ng	16b. Kind of B	usiness/in	dustry
12		E	Elementary/Secondary (0-12)	College (1-4or 5+)	<i>III</i> 9 .		porer			Tohn	Mas	hain Co.
N			17. Father's Name (First, Middle, Last	, N/A		LULE		harla Nama	/Fime Middle	. Maiden Suman		7.(
ĭ		Be	William Doutil	1000					ackson		10)	
Maryland		2	Villiant Deville	1500					-(0,0			
<u>a</u>			19a. Informant's Name/Relationship	1ype, Printi	19b. Mailir		(Street and Num	/	I Houte Numbe	er, City or Town,	State, Zip	Code)
			KINC NWAL/ DI	[NGVI]CV	Place of Dispo		Latiana	Koao	1 ball	miore	NU	21228
5			20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐		cemetery, crer	natory or o	ther place)		ate	20c. Location -		A
Ē	men ant: ury		`4 □Donation 5 □ Other (Speci		MODE	LAN	M	02.0	对· 5	Wood	1awn	IMD
Baltimore,	permit. Departr Importa any inju		21. Signature of Funeral Service Lice	nsee	32	Name an	d Address of Fac	ility P	Ineval.	services	1	
<u> </u>	205 2		Vaugh C	How	5	SIP	altimon	end	TTAKE	2 Balto	D. MI	21229
	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the dea	ath. Do not ent	er the mode	e of dying, such a	is cardiac o	r respiratory a	rrest,		Approximate Interval Between
1										da a u da a		Onset and Death
	/Medical											
	Examiner		Sequentially list conditions. If any, leading to immediate Due to (or as a consequence of):									
		Jer										
V	uted d ansit	直										
ď.	exec in an ial-tr	Examin										
8760,	cate be executed physician and the burial-transit	dlcal		d.								
		O		Y								
Вох	ndin	S	IF FEMALE: 23b. Was decedent pregnant				23d. Date of delivery Month Day Year					
ĕ	leath atte	cla	in the past 12 months? 1									
P.O.	the cy the sched	lsk										
σ.	Physicien: The law requires that the death certific this certificate has been signed by the attending print director, page 2 should be detached for use as	Completed by Physician/M	Part II. Other significent conditions	contributing to death but not re	sulting in the ur	nderlying ca	ause given in Part	11.	23e. Did to	obacco use conti	nbute to th	e cause of death?
qs	uires I sigr Id be	d b	metastatic carcinoma of prostate gland 10						101	Yes 2 No 3 Probably 4 Donknown		
Ö	w requir been si should I	ete							24a. Was an 24b. Were autopsy findings available			
of Vital Records,	sicien: The law certificate has b irector, page 2 s	ш							autop	sy p	prior to con	psy findings available inpletion of cause of
<u></u>	icate icate								1 ☐ Yes		Yes	211 No
ξ.	icier certif ecto	Be	25. Was case referred to medical examiner?	Hospital:				ce of Death	(Check only o	ne)		
<u></u>	Phys this aldir	၉	1 Yes 2 No	1 Management 2 ER/Outpatient 3 DOA 4 Nursing Hom					ne 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
Ē	iding Physicien: th. : After this certifice funeral director, p	o	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Bc. Injury at Work?		8d. Describe f	now injury occurr	ed	
Sic	tend leath tor: , the f	cat	2 Accident investigation 3 Suicide 6 Could not be	<u> </u>				M 1 Yes 2 No				
Division	or At fter c pirec n by	Certification;	4 Homicide Suicide Coold not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					2	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	oital ursa oral [Medical Ce										
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier (Check only (C									
	the the the	Med	one) and manner stated.									
29b. Signature and title of certifier \\ \text{WILLULARS M.D.}						29c. License number				29d. Date signed (Month, Day, Year)		
Ŧ			M.D. RES OOO						February 1st 2005			
	2		30. Name and address of person tho completed cause of death (Item 23a) (Type, Print)									
	8.											
1	State Registrar 31. Date filed (Month, Day, Year) 32. Refistrar's Signature											

Devillasee

State of Maryland / Department of Health and Mental Hygiene 03644 Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2005 **Physician** February 1:56 p Dudding Elizabeth Ann /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Manor Care Ruxton Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) March 26,1915 Illinois Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🖫 F Yrs. 89 263-12-7373 Director Usual Residence of Decedent 10c. City, Town or Location with the Maryland 10d. Inside City Limits 10a. State 10b. County or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 🎗 ☐ No Ocean Pines Directo Maryland Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21811 USA Sundial Circle 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No Specify. Be Completed by 3 X Widowed 4 □ Divorced White "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hiemt: If item 27 Is marked oth Patrick Hamill Martha Mae Cheesman John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ocean Pines, Maryland 21811 LaVergne Troutner / Daughter 14 Sundial Circle or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. Hilltop Service Corp. 2/9/05 Towson, Maryland * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1050 York Road Towson,Md.21204 Lonald R. Watson, Ruck Towson Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page perform 1 ☐ Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 250No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ŧ this After thi funeral of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending within 24 hours atter usam.
To the Funerel Director: Af death. investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D-0012849 necelius) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER Dr. Towson HOHILADI MD. 7600 31. Date filed (Month, Day, Year) Elen & francis Registrar

			1 State	State of Maryland				Mental Hyg	giene 2005	03645
			Registrar		Ceniii	cate of De	eatn		ieg. No.	
	Physicia	an	Decedent's Name (First, Middle, Last)	110				2. Date of Dea Month	Day Year	3. Time of Death
,	/Medic	al	Clerain Di)((1)		0) T		rebrua		510:40AM
	Examin	er	4a. Fecility Name (If not institution, give st	ursina Ho	me 1	City, Town, or Lo	GIVI Death	2 ,	4c County of Dea	MECPI
	F1	_	5. Social Security Number 6. Say	7. Age (In yrs. Ia	st birthday) If U		Under 24 Hrs.	8. Date of Birth) () () () () () () () () () (thplace (State or Foreign
	Funeral Director		217 20 2960	M 2□F 74	Yrs. Mo	nths Days I	Hours Min.	8. Date of Birth (Month, Da) 06 03	1927 Mar	yland
	ס		Usual Residence of Decedent							
	rylan ihow		10a. State 10b. County		Town or Location					10d. Inside City Limits
	Ba-f a	cto	MD Howard	E1.	TICOLL C					1 ☐ Yes 2 🖺 No
	ith th	Dire	10e. Street and Number		10	of. Zip Code			10g. Citizen of What Co	ountry?
	ath w	Funeral Director	10114 Carillon Dr			21042			USA	
	tems	nue		Was Decedent Ever in U.S Amed Forces?	i. 13. Was I	Decedent of Hispa , specify Cuban, I	anic Origin? (S Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
36	s afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ No If Yes, Give Year or Dates:	1 🗆 Y	es 2 No S	Specify:		Specify: Whi	Lte
8	hour	edt	15. Decedent's Educa		16a. Decedent's	Usual Occupatio	20		16b. Kind of Business	/Industry
57	n na	Completed	(Specify only highest grade	completed)	(Give kind	of work done duri OT use retired)	ing most of wor	king	Too. Kind of Eddinosa	, moderny
2	iene r tha	mo	Elementary/Secondary (0-12)	College (1-4or 5+) n/a	Techn	ician			Armco Stee	el Company
ğ	Hyg othe	BeC	17. Father's Name (First, Middle, Last)			18	3. Mother's Nan	ne (First, Middle,	Maiden Sumame)	
<u>lar</u>	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. I marked other than "natural", or items 23a or 28a-f show unastic event, the Medical Examinar must be notified at	ToB	Thomas J. Doyle			7	Jiona (1	unknown)		
an	2 sho and i		19a. Informant's Name/Relationship (Type	1					r, City or Town, State,	
Σ,	ロモアコ		Helena Doyle / Wif				Orive,		City, MD 2	
ore	of H		20a. Mathod of Disposition 1 □ Kurial 2 □ Cremation 3 □ Re	, 20b. Pla moval from State	ace of Disposition metery, cremator Meadowr orlal Pa	(Name of y or other place)	İ	Date	20c. Location - City or	
Ë	. Pag tment tant: jury		*4 □Donation 5 □Other (Specify)					10/2005	Elkridge,	
Baltimore, Maryland 21215-0036	permit. Pages 1 and Department of Heall Important: If Item 2 eny injury or other Otics.		21. Signature of Funeral Service Libensee	Vacas -	22. Nar	me and Address o	of Facility Ga.	ry L. Ka	ufman Fune:	cal Home at
	ac z s a		23a. Part1. Enter the disease, or complicion shock, or heart failure. List only one	ations that arrused the death	7250	lowridge Washingt	ton Blv	d., Elkr	idge, Md 2	LO75
			shock, or heart failure. List only one	cause on each line.	DO HOL BRITAIN	i mode of dying, s	such as cardiac	or respiratory arr	est, -	Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	TISPIKA	170N	INEL	imon,	14		
	Examiner			Due to (or as a conseque	ence of):					
	#	e.	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):					
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
o,	an an rial-tr	Exa	resulting in death) Last	Due to (or as a conseque	ence of):					
8760,	death certificate be executed the attending physician and ad for use as the burial-transit	dicai	d.							
9	ncertifica Inding pt use as t	Med	IF FEMALE:							
Box	eath certif attending for use as	an/l	23b. Was decedent pregnant in the past 12 months?	 If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of 		pic pregnancy			23d. Date of del Month	livery Day Year
	the dea y the al	Physician/Me	1 Yes 2 No	4☐Pregnant at time of dea 9☐ Unknown	ath 5 Oth	er (specify)			Wildital	Day 1 Gai
P.0	± ≥ 3		Part II Other significant conditions conti	shuting to death but not result	ting in the underh	ving cause given i	in Part I	23a Did to	bacco use contribute to	the cause of death?
Division of Vital Records,	es De	1 by	OH) STROK	ß	and an and an adding	ying oddoo giroir i				robably 4 Dunkmown
Ö	w requir been s should	etec	NUCPURA A					_		Lance -
3ec	0 5 0	Completed	DANTHENT					24a. Was a autop: perfor	SV DRIOT TO	utopsy findings available completion of cause of
a		မ င	OF Was soon referred to modical					1 Tes	2DNo 1□Yes	2 1 No
₹		00	25. Was case referred to medical examiner? 1 Yes 2 No	spital:	P/Outpatient 3	Other		th (Check only or		.le.
ō		. To	27. Man of Death		28b. Time of	DOA 28c. Injury at	Section .		ence 6 Other (Spe ow injury occurred	city)
<u>o</u>	Attending Phy ir death. ector: After this by the funeral o	atio	Natural 5 Pending 2 Accident investigation	(Month, Day 19ar)	Injury N	Work? 1 ⊟ Yes	2 □ No			
Vis	or Attend after death Director: /	Hick	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, f	actory, office		28f. Location (S City or Town	treet and Number or Ru	ural Route Number,
Ö	s afte	Certification:		building, stc. (Specify)				Only of You	n, State)	
	Hospital 24 hours a Funeral C	- m	29a. Certifier 1 Certifying Physi (Check only 2 Medical Examine	cian: To the best of my know er: On the basis of examination	rledge, death occi	urred at the time,	date and place	, and due to the c	ause(s) and manner as	s stated.
	the appe	Medica	one) 29b. Signature and title of certifier	and manner stated.		29c. License nu				
	To With		29b. Signature and title or certiner	1-11		290, Elderise III	0.59	-	29d. Date signed (Mont	ni, Day, Year)
	,/		of the state of	allen	00-1 (7:	001	03/1		11/10	
	5		30. Name and address of person who con	HAMI. 742	23a) (Type, Print) 20 1 A	RK HEI	CATIS	AVE	BALTO 1	M 2120 F
3	Sta	ite	31. Date filed (Month, Pays Year) 05	32. Registrar's Signatu						
	Registr	rar	1 50 0 0 5003	The Man Vo.	AND THE CALL	r)/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Naomi 6:50 PM 2005 ebruary 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Hopkins Bayview Merlical Center Baltimore Johns Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 ☐ M 212 F 216-38-6948 86 Yrs. December 20, Md. Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Baltimore MD. Dundalk 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32 Patapsco Avenue 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: 3 Novidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 years **Housewife** Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Evertte Andrew Hoxter Grace Lease 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antonette Bauer Daughter 32 Patapsco Avenue, Dundalk, Md. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State February 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Meadowridge Cemetery 9, 2005 Halethorpe, MD. 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part1. Enter the disease, of complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Respiratory Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Urose PSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown

Physician /Medical Examiner

Department of h Importent: If ite. eny injury or oth

Physician

/Medical

Examiner

Completed by Funeral Director

Be

ပ

Funeral

Director

Show ust be nutified at

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ent: If item 27 Is marked other than "naturel", or Iter

other traumatic event, If a Madical

Baltimore, Maryland 21215-0036

the

à

this

death.

after death Director:

24 hours a Funeral L

within 2 To the

completely

Hospitel or Attending Physicien: The law requires that the death certificate be executed

Box 68760.

P.O. I

Division of Vital Records,

Physician/Medical Examiner use as the burial-transit ρ signed I Be Completed by funeral director, page 2 should Certification; To filled in by the

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

-Term

23e. Did tobacco use contribute to the cause of death?

1)XOYes 2□No 3□Probably 4□Unknown

2 No 26. Place of Death (Check only one) 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident

4 - Homicide

25. Was case referred to medical examiner?

5 Pending investigation 6 Could not be determined 3 Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? М 1 ☐ Yes 2 ☐ No

3□ DOA

Other:

28d. Describe how injury occurred

24a. Was an performed

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 29b. Signature and title of certification

29c. License number Res-000

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940

Eastern Avenne, Baltimore

Registrar

Medical

ramele

32. Registrar's Signature 2005

			For State Registrar	State of Maryla				d Mental Hyg	Reg. No. 0 5	03647
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) James Mil	ton.	Etch	nison		2. Date of Dea Month Februa	Day Year	3. Time of Death 0107 M
ı	Examin		4a. Facility Name (If not institution, give s Northampton Mand		ome	4b. City, Town,	or Location of D		4c. County of Dea Frede	
	Funeral Director		5. Social Security Number 6. Sex		s. last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Birt Month Day Novembe	y Year), 1908 Co	thplece (State or Foreign Sountry Mary Land
	Aaryland f show	٥٢	Usuel Residence of Decedent 10a. State 10b. County Maryland Freder		City, Town or Lo Freder					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the New or 28a-	Direct	10e. Street and Number 116 North Court S	treet		10f. Zip Code	21	701	10g. Citizen of What Co	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23e or 28e-f show entry injury or other traumetic event, the Medical Evarifical must be redified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub		? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, Whit Specify: Whi	e, etc.
21215-0036	within 72 hourene then "nature the Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Dece (Give life. Superv	dent's Usual Occu kind of work done DO NOT use retire 71SOT	pation during most of ed)	working	16b. Kind of Business.	
Maryland 2	uld be filed Aental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, Last) Henry Dorsey Etc	hison	<u> </u>		18. Mother's	Name (First, Middle, Mary Hel	Maiden Surname)	
	and 2 shoralth and N		19a. Informant's Name/Relationship (Ty Tecl T. Mercer/Acco	pe, Print) puntant	19b. Maili 1509	ng Address (Stree Homeste	tand Number of ead Ave.	, Frederi	r, City or Town, State, 2 ck, Marylar	zip Code) nd 21701
Baltimore,	Pages 1 and nent of He and: If item and: If item arry or other		20a. Method of Disposition 1 ☆ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State Mt	Place of Dispo	osition (Name of Peter Cellie 19	ry Feb.	. 4, 2005	20c. Location - City or Fredericle	Town, State k, Maryland
Balti	permit. Departn Imports eny injt		21. Signature of Funeral Service License	Justan	~	106 Eas	st Churc	ord Funera	Frederick	MD 21701
3760,	Physician and burselfansii stee be executed burselfansii stee burselfansii see burselfansii	lical Examiner	29a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Applicating to immediate cause. Enter Underlying Cause (Disease or injury that infitated events resulting in death) Last	Due to (or as a consection of the consection) Due to (or as a consection) Due to (or as a consection)	equence of):	ter the mode of dy	On	diac or respiratory ar	rest,	Approximate Interval Between Onset and Death
P.O. Box 68	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnanc Other (specify)	гу		23d. Date of de Month	ivery Day Year
Records,	The law requires that the death cate has been signed by the atternage 2 should be detached for	Completed by Ph	Part II. Other significant conditions con	ntributing to death but not re		nderlying cause gr	ven in Part I.	1 Y	an 24b. Were at	obably 4 Unknown utopsy findings available completion of cause of
ion of Vital	Jing Physicien: After this certific tuneral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending investigation	lospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Inju	her: 4 ursir	-	ne) dence 6 □Other (Spe now injury occurred	cify)
Division	i Siri	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, sti	reet, factory, office		28f. Location (S City or Ton	Street and Number or Ri vn, State)	ural Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) Certifying Physical Exemi	sician: To the best of my kiner: On the basis of examinand manner stated	nowledge, deat nation and/or in	h occurred at the to vestigation, in my	ime, date and p opinion, death o	lace, and due to the occurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
)	To t To tl	Σ	29b. Signature and title of certifier	1 Cli	m	M D	se number L6428	:	29d. Date signed (Mont	h, Day, Year)
6)		30. Name and address of person who concerns the Casper E. Clin 31. Date filed imports Day, Year)	ne III. M.D.	. 300 W		h Stree	t, Frederi	ck, MD 217)1
	Sta Registi		FEB 0 8 200	Registrar's Sig	& Age	Me				

			1 - For State Registrar		State of Ma	aryland / Dep <i>Ce</i>	ertificate of l	Health and N <i>Death</i>		giene Rog. No.	2005	03648
	Physici			e (First, Middle, Las rgaret	,	Eckman			2. Date of De Month Februar	ath y 5,	2005 ^{ear}	3. Time of Death
	/Medic Examin		4a. Facility Name (I	f not institution, give	street and number)		4b. City, Town, o	or Location of Death)	4c.	County of Dea	10
					cent Cente			Crofton			Anne Arundel	
	Funeral Director		5. Social Security N 216-42-9	9003 1	ex 7. Ag □M 2 Ag F	e (In yrs. last birthday 96 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Nov. 1.	y, Year)	9. Bir 908 Mar	thplace (State or Foreign country) yland
	and		Usual Residence of 10a. State	Decedent 10b. County	·	10c. City, Town or L	_ocation					10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show rmat be notified at	Ιō	MD	Anne Aru	nde1	Odenton						1 ☐ Yes 2 ☐ No
	r 28a	irec	10e. Street and Nur			343773	10f. Zip Code			10g. Citiz	zen of What C	ountry?
	th with	ai D	2502 Amb	er Orchar	d Court W.	Unit	21113			U.	S.A.	
30	72 hours after death with the Marylan "natural", or Items 23a or 28a-f show olical Examinat be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 ☑ Widowed	ed 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If If Yes, Give Year or Dates:	Ever in U.S. 13	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No		pecify Yes or No o Rican, etc.)	ĺ	14. Race - Ame Black, Whit Specify: Wh:	te, etc.
5-0036	2 hou	ted t		15. Decedent's Ed	lucation	16a. Dec	edent's Usual Occup	pation	1		MII.	
2	within 72 ho ene. than "natur ne Medical	Completed	(Spec	ify only highest gra	de completed) College (1-4or 5	(Giv	e kind of work done DO NOT use retire	during most of world)	king			of Maryland
7	filed with Hygiene other the ant, the	Som	12	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	3011090 (1 401 0	Cle	rical Off	ice		Mai	n Dinir	ng Hall
and	a d la b	Be		(First, Middle, Last)				18. Mother's Nam			Sumame)	
\leq	d Men d Men narke	Ç		y Morton	Suna Print)	10h Mai	ling Address (Street		stephens		. T	To Code 1
Mar	id 2 sith an ith an traur				ond/Daught							enton, MD2111
nore,	Pages 1 and nent of Health int: If item 27 iry or other to		20a. Method of Disp	oosition Cremation 3	Removal from State	20b. Place of Disc		tion Febr	Date Cuary	20c. Loc	cation - City or	Town, State
altimor	pernit. Page Department of Important: If any injury or once.			5 Other (Specify neral Service Licen			22. Name and Addre		2005			e, Maryland ome, P.A.
ñ	Den Sany Pany Pany Pany		John	0.	O Lhura	100710		01				yland 21061
İ,	4		shock, or hea	rt failure. List only	olications that caused one cause on each lin	10.						Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (disease or condition resulting in death)		a Athero		Sic Can	dio Vasi	Cular,	0154	use	years,
	Examiner				Due to (or as	a consequence of):	et.					Michigan D
		Jer	Sequentially list confiany, leading to in cause. Enter Under Cause (Disease or	nditions, imediate	b. Due to (or as	a consequence or):	1					Jews .
	cuted nd ransit	Examin	that initiated events		c							
Š	ficate be executed physician and ts the burial-transit		resulting in death) I	ast	Due to (or as	a consequence of):						
08/PN	cate b ohysic the b	edical			d.							
	E 00 6		IF FEMALE:		23c. If yes, outcome	of pregnancy					2d Data of da	ih.aa.
X R O	death certif e attending ed for use as	Physician/M	23b. Was deceden in the past 12 1 \(\superset \text{Yes} \) 2 \(\superset	pronths?		2 Fetal death 3	☐Ectopic pregnanc ☐ Other (specify) _	у		2	3d. Date of de Month	Day Year
J.	that the de ned by the a detached f	hysi	9 □Unknown	2140	9□ Unknown							
-	law requires that the as been signed by th 2 should be detache	by	Part II. Other signif	icant conditions o	ontributing to death b	ut not resulting in the	underlying cause giv	ven in Part I.	23e. Did to	Cale	400	o the cause of death?
Š	requ been should	etec							-			
Vital Records	The ate h page	Completed									24b. Were at prior to death?	utopsy findings available completion of cause of
V 118	ysician: is certific director,	Be	25. Was case refer examiner?	,	Hospital:		Ott	26. Place of Dea				
ō	Phy this	2	1 Yes 2 2		1 ☐ Inpatie		ent 3 L DUA		ome 5 Resid			cify)
0	ding th. : After	tion	1 TNatural 2 Accident	5 Pending investigation	(Month, Day	Year) Injury	Wo	rk? Yes 2 □ No	200. 0000100 11	iow inquity	00041104	
DIVISION	Atten r deal ector: by the	ifica	3 Suicide	6 Could not be determined	28e. Place of Inju	ury - At home, farm, s					l Number or Ri	ural Route Number,
5	tal or	Certification:	4 Homicide	,	building, etc	c. (Specify)			City or Tow	m, State)		
	To the Hospital or Attending PP within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	ysician: To the best of finer: On the basis of and manner sta	examination and/or i	th occurred at the til nvestigation, in my o	me, date and place, opinion, death occur	and due to the orred at the time, or	cause(s) a date and p	and manner as place, and due	s stated. to the cause(s)
	To the To the company	×	29b. Signature and	title of certifier	-1000	CI	29c. Licens	-		29d. Date	signed (Mont	h, Day, Year)
	ın		30. Name and addr	esstof person who	completed cause of d	eath (Item 23a) (Type), Print) – –	12010	X	2	-17/0)
	10		120	Mesi	1 Arr	ma	1430	10 69	llant	- 4	nL	n ams
	Sta Registr		31. Date filed (Mon	- 2 2	87	ar's Signature	rate .					
			k kai	w acc.	1 0 0 9 1 9 m	- July	-					

	1- For State of Registrar	Maryland / Depa Cer	rtment of H			ene 2 (105	0364
Physician	Decedent's Name (First, Middle, Last)	ทธกร			2. Date of Death Month 02	Day O2	Year	3. Time of Death 5'50 4 M
/Medical Examiner	4a. Facility Name (If not institution, give street and num		4b. City, Town, or Ba	Location of Death		4c. County		
Funeral Director	245-42-3311 10M 2KF	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	rear)	9. Birthpl Count	ece (State or Foreign try)
Maryland f show	Usual Residence of Decedent 10a. State 10b. County MD Baltimore	10c. City, Town or Loc Balt	cation more				10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
Safer death with the Mar frience 23e or 28e-1 st interpretal Director	10e. Street and Number 2121 Windsor Garát	en Ln. #311A	10f. Zip Code	1207	109	g. Citizen of	What Coun	try?
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "natural", or items 23s or 28s-1 show or other traumetic event, the Medical Examinar must be notified at To Re Completed by Euperal Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes If Yes, Giv Year or Div	2 No 1	Vas Decedent of Hi. Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rad Bla Specif	ce - America ck, White, e	an Indian, etc.
Baltimore, Maryland 21215-0036 bernit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Inportant: if item 27 is marked other then "natural; or mortant: if item 27 is marked other then "natural; or page. To Re Completed by E	(Specify only highest grade completed) Elementary/Secondary (0·12) College,(1	16a. Deced (Give life. D	A	ation Juring most of worki	ing 16	6b. Kind of B		lustry Care
should be filed within and Mental Hygiene. Imarked other then immitte event, the Mental Hygiene.	12th grade N/A 17. Father's Name (First, Middle, Last) Mack Baine	t Nu	rse ris	18. Mother's Name	Arnette			
e, Maryla 1 and 2 should I Health and Men 1 is marke- inther traumatic	19a. Informant's Name/Relationship (Type, Print) Gome Emmons/H			and Number or Rura				Code) D 21207
Baltimore, permit. Pages 12 Department of He Important: If Item any injury or oth once.	20a. Method of Disposition 1	Crownsi	natory or other place	0.2.0	9.05 (Oc. Location VOWVE	ville,	MD
Ball permit Depart Import Import any in	21. Signature of Funda Service Licensia			s of Facility seen. Fur hore Nation			e MD	
Physician /Medical	23a. Part1. Ent the disease, or complications that control shock, or he if failure. List only one cause on elimmediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	4 1 0	g, such as cardiac c		51,		Approximate Interval Between Onset and Death
examiner on and in-transit Examiner Frame in the control of the	cause. Enter Underlying Cause (Disease or injury	or as a consequence of):						
₩ 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	that initiated events c.	or as a consequence of):		- 44-14				
Records, P.O. Box 687. The law requires that the death certificate the has been signed by the attending physicage 2 should be detached for use as the bornolesed by Dhyelr landMadding	250. Was decedent pregnant	ant at time of death 5	Ectopic pregnancy Other (specify)				ite of delive	ry Day Year
Cords, P. requires that the been signed by should be detailed by Dh	Part II. Other significant conditions contributing to de	eath but not resulting in the un	nderlying cause give	en in Part I.		acco use con	tribute to th	e cause of death? ably 4 Winknown
					24a. Was an autopsy perform		Were autop prior to con death? 1 Yes	osy findings available inpletion of cause of
of Vita of Vita hysician: his certific		npatient 2 ER/Outpatient of Injury 28b. Time of		ar: 4 ☐ Nursing Ho	me 5 Residen 28d. Describe how	nce 6 20tl		Hospice
Division of or Attending Parter death. Director: After the funeral in by the funeral or attendent or attenden	1 Matural 5 Pending (Mont 2 Accident 3 Suicide 4 Homicide 6 Could not be determined 28e. Place building	th, Day Year) Injury of Injury - At home, farm, streng, etc. (Specify)	M 1 🗆 '	Yes 2 □No	28f. Location (Stre City or Town,		ber or Rura	l Route Number,
Hospita 4 hours Funeral		best of my knowledge, death asis of examination and/or inv ner stated.	occurred at the time	ne, date and place, pinion, death occurr	and due to the cau	use(s) and m te and place,	anner as st and due to	ated. the cause(s)
To the within 2 To the complete	29b. Signature and title of certifier	101 3(4)(0).	29c. License	4170	290 F	d. Date signe	ed (Month, I	Day, Year)
4	30. Name and address of person who completed caus	en traice	Print) 8 N	Eutaws	Tal	timor	e M	1 21201
State Registra	31. Date filed (Month, Day, Year) 32. R	egistrar's Signature	20					

ORIGINAL

J			State Unpend Item 23a,	te of Maryla 27,28a-f	nd/Depa per me <i>Cel</i>	artment of H C840 2-17 rtificate of I	lealth and : 7-05, tas Death	Mental Hyg	iena 005	03650
	Physici	an	Decedent's Name (First, Middle, Last)	-			10 day 100 da 100 gay a 100 gay 100 gay 100 gay 100 gay 100 gay 100 gay 100 gay 100 gay 100 gay 100 gay 100 ga	2. Date of Deat Month	h	3. Time of Death
	/Medic	al	DOMINIC JOSEPH F 4a. Fecility Name (If not institution, give street			4b. City, Town, or	Location of Deat	Februar	y 7, 2005 4c. County of De	
	Examin	ler	Wolman Hall 3339 Char		309 B		Ltimore		N/A	211
	Funeral		5. Social Security Number 6. Sex		. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)
	Director		144-78-7515 1 X M 2	19	Yrs.			Apr 26,		lew Jersey
	iryland thow		10a. State 10b. County	10c. C	ity, Town or Lo					10d. Inside City Limits
	he Ma 28s-1 s	Director	PA Bucks County	7	Doy1e	estown		T.		14 Yes 2 No
	3a or	ΙΩ	10e. Street and Number 355 Maple Avenue			10f. Zip Code	3901	11	0g. Citizen of What 0	ountry?
	death	Funerai	11. Marital Status 12. W	as Decedent Ever in I	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		Specify Yes or No-	USA 14. Race - Am	
36	72 hours after death with the Maryland "natural, or Itams 23a or 28a-f show citcal Examinar must be notified at	by Fu	1 Never Married 2 Married 1 [☐Yes 21X No Yes, Give		1 □ Yes 2 🎇 No	Specity:	to rican, etc.)	Black, Wh	White
2-00	72 hounature	eted	15. Decedent's Education (Specify only highest grade com.		16a. Dece	dent's Usual Occupa	ation	rking	16b. Kind of Busines	s/Industry
21215-0036	within ane. than "	Completed		llege (1-4or 5+)	life.	DO NOT use retired	i)	Nail 9	Educatio	
d 2	a filed within Hygiene. other than vent, the M	Be Co	17. Father's Name (First, Middle, Last)			Student	18. Mother's Nar	me (First, Middle, A	Education Surmanne))[]
/lan		To B	Joseph Dominic Ferr	ara, M.D.			Carol	ine		Vargas
Maryland			19a. Informant's Name/Relationship (Type, Pr			ng Address (Street a	and Number or Ru	ıral Route Number,	City or Town, State,	Zip Code)
	1 an Heal em 2 ther		Dr. Joseph D. Ferrara 20a. Method of Disposition	20b.	Place of Dispo	Maple Ave	1	lestown,	PA 18901	r Town, State
E O			1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov. 1 ☐ Donation 5 ☐ Other (Specify)	ai ii Oili State		natory or other place Cremator	1	/2005 1	Lansdale,	DΛ
Baltimore,	permit. Page Department important: if any injury or once.		21. Signature of Force al Service Licensee	m	22	. Name and Addres	s of Facility		Home, Inc	
	40 = 6 d		Martin D. Lawson 23a. Part1. Enter the disease, or complication	s that caused the dea	6.	500 York	Road, Ba	1timore,	Maryland	21212 Approximate
	Physician		Immediate Cause (Final	se on each line.	ion bottor on	or the vibas of dying	g, odon as cardiac	or respiratory arre	51,	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	sphyxia Due to (or as a conse	quence of):					
		-	Sequentially list conditions, b	Due to (or as a conse	quence of):					
V	outed id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		40000 0.7.					
90,	ificate ba executed g physician and as the burial-transit	I Exc		Due to (or as a conse	quence of):		- <u>-</u>			
68760,	ficate I physics the t	edical	d							
Box	th cert anding r use	an/M	230. Was decedent pregnant	res, outcome of pregr Live birth 2 Fet		Ectopic pregnancy			23d. Date of de	alivery
O. E	Q 0 Q	Physicia	1 Ves 2 No	Pregnant at time of Unknown		Other (specify)			Month	Day Year
s, P.	→ ⊕ ∪	by Ph	Part II. Other significant conditions contributi	ng to death but not re	sulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute t	to the cause of death?
ords	w requires been sign should be							1 □ Ye	s 2□No 3□P	robably 4 Unknown
Vital Record	e 2 s	ompleted				-		24a. Was ar autopsy perform	prior to	autopsy findings available a completion of cause of
tal	T age	e Co	25. Was case referred to medical				26 Plane of Dog		□ No 15 Te	s 2□No
of Vi	yaic iis ca direc	To B	examiner? 1 XYes 2 No Hospita	l: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatien	t 3□ DOA Othe			nce 6 ⊠Other (Spe	ecify) At scene
	ling After une		1 □Natural 5 □ Pending Fo	Date of Injury (Month, Day Year)	28b. Time of Fourth	Work	(?	28d. Describe ho		1 16
Division	ten leal lor tha	Certification:	3. Suicide 6 □ Could not be 286	7-05 Place of Injury - At h	12:00 nome, farm, str	A	Yes 2 No		asphyxiate eet and Number or B	
D	- t t		4 L Homicide	pullding, etc. (Speci	ify)			Baltimore	State) 3339 (e, Md	Unal Route Number. Charles St.
	To the Hospital or within 24 hours af To the Funeral D completely filled in	ledical	29a. Certifier 1 Certifying Physician: (Check only one) 2 Medical Examiner: O ar	To the best of my kn n the basis of examin of manner stated.	owledge, death ation and/or inv	occurred at the time restigation, in my op	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the comp	Ň	29b. Signature and title of certifier	QM.	,	29c. License		29	d. Date signed (Mon	, ,
•			1 Tou Un	~ [Oll	Lus	OCM	<u> </u>		February	i, 2005
	5		PARICIA Aroni W	- Kollak	N)		nn Stree	t Baltimo	re, Maryla	and 21201
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 8 2005	32 Aegistrar's Sign	t de	2020				

			For State Registrar	State of Maryland		artment of F rtificate of			gienne 0 0 5	03651
		97	Decedent's Name (First, Middle, Last	t)				2. Date of Dea		3. Time of Death
и	Physici /Medic		William			rair		Februa	4 4	- 0530 A M
Ē	Examin	- 0	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County of De.	ath
		i a	The Johns Hop	okins Haspital		Baltim	ore Cit	4	NA	
	Funeral	27	Social Security Number 6. Security Number	9 . ,		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h 9. Bi	rthplace (State or Foreign Country)
×.	Director		217-10-9000	□ ^{M 2□} F 80	Yrs.			8-20-		S.C.
	pu 🛊		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	sho	5	Md. NA	, ,		imore				1X Yes 2 No
	28a-1	Director	10e. Street and Number			10f, Zip Code			10g. Citizen of What C	Country?
	hours after death with the Maryland tural', or Itams 23s or 28a-f show at Examinar must be notified at			Charach		2120	15		USA	
	eath	Funeral	1618 E. Madison	12. Was Decedent Ever in U.S	S. 13.	Was Decedent of H	Hispanic Origin? (S	pecify Yes or No-		ieńcan Indian,
10	fter d r Itan iner	F	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 XYes 2 □ No		If Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)	Black, Wh	· .
936	urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yes X□ No	Specify:		Specify:	Black
21215-0036	72 ho natur dical	ted	15. Decedent's Ec		16a. Dece	dent's Usual Occup	pation	rking	16b, Kind of Busines	s/Industry
21	within 7 ene. than "r	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	King	Militares	
21	filed wi Hygien othar th	Completed	12th grade		A	thletic I			Military	
nd	ould be filed withi Mental Hygiene. arked othar thar atic avent, Ina M	Be	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
yla	should ind Menions marker	2	William	Fair			Estel		McQuarte	
Maryland	A1 (0 W) (0		19a. Informant's Name/Relationship (Sister					ar, City or Town, State, Baltimore	
	Health tam 27		20a. Method of Disposition		_	osition (Name of	all Ave. A	Date	20c. Location - City of	
Š	Pages nent of H int: If its iry or of		1 🕏 Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, cre	matory or other pla			,	·
altimore,	permit. Pa Departmer Important any injury		 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licer 		oudon	Park 2. Name and Addre		-05	Baltimor	
Ba	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		21. Signature of Purioral Servica Liter	104		Baltimore		202	March F.H. 1101 E. No	
-			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused the death	. Po not en	ter the mode of dyi	ng, such as cardiad	or respiratory ar	rrest,	Approximate Interval Between
No.	Pnysician		Immediate Cause (Final	one cause on each line.						Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (o \s a consequ	uence of):					12 Mail
1	Examiner		Conventially list conditions	b						
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of mounts	Due to (or as a consequ	uence of):					
	acute ind trans	Examiner	that initiated events resulting in death) Last	c						1
90,	e exe	Ω.	resulting in death) cast	Due to (or as a consequ	Jence of):					
8760,	licate be executed physician and s the burial-transit	dical		d						
9	death certifica a attencing pt d fo ure as ti	a a	IF FEMALE:	23c. If yes, outcome of pregna	nev				20d Date of d	
Box	athen fo u:	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetat 4 Pregnant at time of de	death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of d Month	Day Year
	that the de ed by the detached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	Sati St					
P.0	The law requires that the death certificate has been signed by the attending tage 2 should be detached to use as	/ Ph	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	ınderlying cause gi	ven in Part I.	23e. Did to	obacco use contribute	to the cause of death?
of Vital Records,	uires tha signed	d by	hypertension, hi	story of atr	inl f	brillat	101	1 🗆 1	Yes 2□No 3□1	Probably 4 Unknown
000	w require been si should l	lete	hypothyrodim	Stentin past	F 61.	lat Lan		24a. Was		autopsy findings available
Re	sician: The law s certificate has b lirector, page 2 s	Completed	1 10.21311	24410		3100 120			osy prior to inned?) death? 2500 1 2 Ye	completion of cause of
tal	an: T tificat or, pa	a	25. Was case referred to medical				26. Place of Dea	1 Yes		
>	ysicia s cer direct	OB	examiner?	Hospital: 1 patient 2	ER/Outpatie	nt 3□ DOA Ott	hor		dence 6 □Other (Sp	ecify)
0	ding Phys	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Inju Wo	ry at	28d. Describe h	how injury occurred	
0	ath. rr: Aff	atlo	1 Accident 5 Pending investigation	1	,,		Yes 2 □No			
Division	er de racto	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify)	ome, farm, st	reet, factory, office		28f. Location (S City or Tox	Street and Number or I vn, State)	Rural Route Number,
	italo irsaft ral Di led in	Ce								
	To tha Hospital or Attending Physician: The within 24 hours after death. To tha Funaral Diractor: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier Certifying Pt (Check only 2 Medical Exar	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, dea tion and/or in	th occurred at the ti rvestigation, in my	ime, date and place opinion, death occu	e, and due to the erred at the time,	cause(s) and manner a date and place, and de	as stated. ue to the cause(s)
	o tha o tha omple	Mec	29b. Signature and title of certifier	and mainter stated.		29c. Licen	se number		29d. Date signed (Moi	nth, Day, Year)
	F ≯ F ŏ		1 95 2th:	MO, PhO		RES	-000	1	February L	1,2005
	IND	/	30. Name and address of person who	completed cause of death (Item	1 23a) (Type	, Print),		600	North h	JOHR Street
-	11/		Victoria Haiao,	MD, Johns Ho	opkin	s Hospita	il, Towerl	10, Bal	Himore, M	aryland 21287
	¹⁵ ∌ Sta	ate rar	31. Date filed (Month, Day, Year)	completed cause of death (Item MD, Johns Ho 32. Registry's Signa 8 2005	ture &	Sporte	•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Degedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Februa /Medical 4a. Facility Name (If not institution, give street and number) c. County of Death 4b. City. Town, or Location of Death **Examiner** center Social Security Number 7. Age (In yrs. last birthday) 82 Yrs. 8. Date of Birth (Month, Day Funeral Months 1□M 2**M**F Days Hours Min Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Completed by Funeral Director 1 ☐ Yes 2 ☑ No 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code APT Was Decedent Ever Armed Forces? 1 __Yes _2 DNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status n U.S 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fit and Mental H Be ZOVOSKI nknow 19b. Mailing Address (Street and Number or Rural Roul, Number, City or Town, State, 19a. Informant's Name/Relationship (Type, Print) oorah 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial 2 ▼Cremation 3 □ Removal from State 20c. Location - City or Pages 1 permit. Pages Department of Important: if it any injury or o ° 4 □ Donation Evans 5 ☐ Other (Specify) Charel Belair a 6 0 Forest III III 22 Nation and disess of Fapility natives funeral + cremation and action of the same and 21093 center BelAIR 21. Signature of Funeral Service Licenses That Enter the disease, in comparison ation that caused the death. Do not enter the mode or dying, such as cardiac or respiratory arrest, adjuste Cause (Final). Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ung CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Under in J Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the burial-transit Due to (or as a consequence of): JF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month 4☐Pregnant at time of death 5 Other (specify) Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ disease 3 ☐ Probably 4 ☐ Unknown 2 No 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 240 No Vital 1 Yes 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: P 1 ☐ Yes 2 ☒ No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical To the 29b. Signature and title of certifier 29c. License number

Registrar

State

us

701

30. Name and address of person who completed cause of feath (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

BIN

25205

ale St. Balto. md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** KICHARD FLOYD 3,2005 120 PM Februar /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** MERCY STELLA! PARIS AT BALLI MORZE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours **№** M 2 🗆 F Yrs. Director 313-32-9250 Pa F26.16 1935 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits ral, or items 23a or 28a-f show Examination routined at Yes 2 No Director (JARY LAW BALLINORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? AVE US.A 3939 91917 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: WHILE Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) IMPOUND LOT FOR Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. SNOW THAD TO YTI'L AUTO WORKER Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1504 EVELYN FAY BURNS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If Item 27 Is any injury or other trauonce. 3040 FOURTH HVI. 1 KZNSAI PATRICIA H. KAUFMANN CORLYSA! Baltimore, 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State 200. Place of Disposition (Name of commence)

Commence of the place of JEST. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State *4 Donation 5 Dother (Specify) • CAPKERITY LEH TERROT BUNATIVES FURSAL ALDERGAT MICES 21. S na tre of Eune al Service Licensee 1 MOUNT 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lolon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 24a. Was an 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 No 2 1 🗌 Yes this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1XNatural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21412005 D4082A no completed cause of death (Item 23a) (Type, Print) 30. Name and address of person wh Play Bultmer 21202 David egistrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

			1 - State Registrar	ate of Maryland		rtment of F		Reg	g. No. UU5	03654
	Physici /Medi			FOWLER				2. Date of Death Month February	Day Year	3. Time of Death 6:00 A. M
	Examir		4a. Facility Name (If not institution, give stree 2111 Sulgrave Avenu 5. Social Security Number 6. Sex	,			imore If Under 24 Hrs.	9 Date of Birth	4c. County of Dea	th thplace (State or Foreign
	Funeral Director		218-42-6345		Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day,) Jan. 6,	1930 En	gland
	ne Marylan 8a-f show	ector	Maryland N/A		Town or Local	е				10d. Inside City Limits 1 X Yes 2 ☐ No
	h with ti 23a or 2 31 be n	al Dire	10e. Street and Number 2111 Sulgrave Avenue	2		10f. Zip Code	1209	10	g. Citizen of What Co U.S.	
980	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Itam 27 is marked other than "natural", or items 23a or 28a-1 show other traumetic event. It a Medical Examination and its majoral Examinations.	by Funeral Director	1 Never Married Married 1	Vas Decedent Ever in U.S. Armed Forces? □ Yes 2 X No 1 Yes, Give Year or Dates:		as Decedent of H Yes, specify Cub:	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
215-0036	within 72 ho lene. than "natur I'e Medical	Completed	15. Decedent's Education (Specify only highest grade control Elementary/Secondary (0-12)	mpleted) College (1-4or 5+)	(Give k life. Di		during most of work d)	ing	6b. Kind of Business	/Industry
nd 21	ould be filed with Mental Hygiene. arkad other than atic evant, Iten	Be Cor	17. Father's Name (First, Middle, Last)	+ years	Nur	:se/Midw		e (First, Middle, Ma	Medica aiden Surname)	al
Maryland	should that Ment markad	2	Harry 19a. Informant's Name/Relationship (Type, I	Bird	19h Mailing	Addrass /Street	The second second second second		Vright City or Town, State, .	Zin Code)
Baltimore, Ma	0 0			usband) 20b. Plac	2111 ce of Disposi netery, crema	Sulgrave tion (Name of atory or other place	e Avenue	Baltimor Date 20	e, Maryla Oc. Location - City or	nd 21209 Town, State
Baltir	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	Gree	22. M:	nt Crema Name and Addre tchell- 500 Yor	ss of Facility Wiedefeld	Funeral	Baltimore, Home, Inc Maryland	•
	Physician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one commediate Cause (Final disease or condition resulting in death)	ons that caused the death. use on each line. Due to (or as a conseque	Do not enter	the mode of dyir		or respiratory arres	c VA	Approximate Interval Between nset and Wath
8760, <	physician and purial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent						
Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?	f yes, outcome of pregnand 1 ∐Live birth 2 ∏ Fetal d 4 ∏Pregnant at time of dea 9⊒ Unknown	leath 3 □E	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year
rds, P.O.	quires that t n signed by uld be detar	ed by Ph	Part II. Other significant conditions contribu	uting to death but not resulti	ing in the und	derlying cause giv	ren in Part I.			o the cause of death?
al Records,	The ate h	Completed by						24a. Was an autopsy performe 1 Yes 2	prior to	utopsy findings available completion of cause of
of Vital	Phys this aldi	n; To Be		1 Inpatient 2 El	R/Outpatient	3 DOA Oth	er: 4 Nursing Ho	me 5 Nesiden 28d. Describe how	ce 6 □Other (Spe	cify)
Division	To the Hospital or Attending F within 24 hours after death. To the Funaral Director: After completely filled in by the funer.	Certification:	Accident Suicide Homicide Natural S Pending investigation Gould not be determined 2	8e. Place of Injury - At hom building, etc. (Specify)	Injury ne, farm, stree	M 1 🗆	Yes 2 ☐ No	28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
	24 hours a Funaral stely filled	edical C	(Check only 2 Medical Examiner:	n: To the best of my knowle On the basis of examinatio and manner stated.	ledge, death on and/or inve	occurred at the tirestigation, in my o	me, date and place, ppinion, death occurr	and due to the cau ed at the time, dat	ise(s) and manner as e and place, and due	s stated. to the cause(s)
)	To the within 2 To tha complei	Me	29b. Signature and title of certifier			29c. Licens			d. Date signed (Mont	
	4		30. Name and address of person who complete G/BSON	eted cause of death (Item 2	, ,	okins t	6SPITAL	BACT.	MORE V	7 2005 MARYUNA
	Sta Regist	ate	31. Date filed (Month, Day, Year) FFR 0 8 2001	32. Redistrar's Signatur	re	1				

		1 = For State Registrar	State of M		epartment o		ind Mental Hy	giene 005	03655
Physici /Medio Examir	al	Decedent's Name (First, Middle, Las Ruth 4a. Facility Name (If not institution, give Citizens Nursing	Vi		7.	n, or Location o		Day Year 2005 4c. County of Dea	3. Time of Death 0955 M th erick
Funeral Director		5. Social Security Number 214-10-1429 6. Se		ge (In yrs. last birth	day) If Under 1 Y			rth 9 Bir	thplace (State or Foreign ountry) Maryland
Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Frede	erick	10c. City, Town		rederick	ζ		10d. Inside City Limits 11 Yes 2 □ No
h with the	ai Dire	2507 Coach House	Way, 2-P	3	10f. Zip Co	21702	2	10g. Citizen of What Co. U.S.A.	ountry?
peditiniole, Index yiello ZIZIS-00000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any highry or other traumatic evant. The Medical Examinar must be incillised at once.	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	i?] No	13. Was Decedent If Yes, specify (gin? (Specify Yes or No Puerto Rican, etc.)	o- 14. Race - Ame Black, Whi Specify: ₩ni	te, etc.
within 72 h iene. rthan "natu	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or	(5+)	Decedent's Usual Or 'Give kind of work do life. DO NOT use re nistrativ	one during most ntired)		16b. Kind of Business U. S. Gover	·
id be filed ental Hyg ked othal ic evant.	To Be C	17. Father's Name (First, Middle, Last) George C. Doll					r's Name <i>(First, Middle</i> Ruth V. Loc	, Maiden Sumame)	
Mary nd 2 shou lith and M 27 is mar r traumat	-	19a. Informant's Name/Relationship (7 Ralph E. Fry/Husl		19b. 25	Mailing Address (St. 507 Coach	reet and Number House V	r or Rural Route Numb Nay, 2-B,	er, City or Town, State, Frederick,	Zip Code) MD 21702
Pages 1 ar		20a. Method of Disposition 1		20b. Place of I	Disposition (Name of Contract	/ Metery	Feb. 3, 20	20c. Location - City or 05 Frederi	Town, State .ck, Maryland
partitification permit. Pages Department of Important: If it any Injury or o once.		21. Signature of Funeral Service Licens	/ //	fa M00021	22. Name and A Keene	ddress of Facility y and Ba	asford Fune	eral Home	MD 21701
Physician /Medical		23a. Part1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	ŲV.	aum	dying, such as o	cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
Examiner	-i-	Sequentially list conditions, if any, leading to immediate	b	s a consequence of					
cate be executed physician and the burial-transit	Ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	s a consequence of	·):				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		e of pregnancy 2 ☐ Fetal death at time of death	3 □Ectopic pregn 5 □ Other (specify			23d. Date of de Month	livery Day Year
r requires that the second of the second period by should be detailed.	ρχ	Part II. Other significant conditions co	ntributing to death	but not resulting in	the underlying cause	given in Part I.		tobacco use contribute to Yes 2 ☐ No 3 ☐ Po	. /
VICAL INCOLLA rsiclan: The law requir s certificate has been si lirector, page 2 should I	Completed						24a. Was auto perfo 1 □ Yes	psy prior to death?	utopsy findings available completion of cause of
ding Physician: The thing Physician: The this certificate his funeral director, page	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpat		patient 3 DOA me of 28c. M		28d. Describe	one) idence 6 Other (Spe	cify)
after dea	Cerlification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of II	njury - At home, farr etc. <i>(Specify)</i>	m, street, factory, of	ice		Street and Number or Ri wn, State)	ural Route Number,
To the Hospital or Attendi within 24 hours after death. To tha Funaral Director: A completely filled in by the it	edical C	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	vsician: To the besiner: On the basis and manner s	of examination and	death occurred at the	ne time, date and ny opinion, deat	d place, and due to the h occurred at the time,	cause(s) and manner as date and place, and due	s stated. to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier		MD	29c. Lie	D5839	91	January 3	
8		30. Name an address of poor no consideration Sajjed Aziz, M.D.				rederic	k. Marvlan	d 21701	
Sta Registi		Sajjed Aziz, M.D	5 Regis	trar's Signature	freele				

State of Maryland / Department of Health and Mental Hygiene 03656 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 7:29 PM Lillian Myrtle Franey tebrucon 2005 /Medical c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs.

Wonths Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2 1 F 78 April 18,1926 Maryland Director 214-20-6664 Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10c. City. Town or Location 10a State 10b. County 1X Yes 2 □ No Directo Maryland Baltimore 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number *natural", or items 23a or 4905 Cedargarden Road 21229 U.S.A. by Funeral death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2K Marned 21215-0036 1 ☐ Yes 2X No Specify: Specify: If Yes, Give Year or Dates: White 3 ☐ Widowed 4 ☐ Divorced ntal Hygiene.

d other then "natura: event, ine Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) is marked Frederick Weaver Myrtle Walston permit. Pages 1 and 2 shoul Department of Health and Milmportant; if Item 27 is mariany injury or other traumations. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert Allen Francy (Son) 4526 Turkey Farm Place Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 2-9-2005 Woodlawn, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Witzke Funeral Home of Catonsville, 1630 Edmondson Avenue Catonsville, 21. Signature Ineral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acure INFARCTION 24 his **Physician** MYOCARDIM disease or condition resulting in death) /Medical Due to (or as a consequence of): Soyeas Examiner CORONNE HEATER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐Live birth 2 Fetal death Month Day Year ō in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 20 No detached the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown MYPERETENSION peeu DI HUBECES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy RENSS 2/2 No 1 Yes 2 No this certificate FAILLERE 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 10 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death in by the 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a pellij 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Q D 36373 February 4, 2005 eter cause of death (Item 23a) (Type, Print) 30. Name and address of be son 3448 WILKENS AVE #300 BALLO 2122 A. MARRIN BYC 205200 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

- 100	ı
100	
100	
100	
J	
V	
Ć.	
09289	
œ	
9	
×	
Š	
$\mathbf{\omega}$	
-	
O	
Δ.	
-	
S	
5	
5	
Ö	
Record	
ш	
65	
*20	
5	
-	
0	
5	
-	
-27	
.≥	

	Please 1	Type or Print in Black State of Maryland		lealth and Mental I		03657
•	1. Decedent's Name (First, Middle, Last,			2. Date o	f Death	3. Time of Death
Physician /Medical	Gwendolyn	L. Fitch		Month	Day Yea	
Examiner	4a Facility Name (If not institution, give	street and number) SUNA HOME	4	4b. City, Town, or Location of C Baltimore	Death 4c. County of D	eath /A
Funeral Director	5. Social Security Number 6. Sea	7. Age (In yrs. las	t birthday) If Under 1 Year Months Days	Hours Min. 8. Date o	f Birth Day, Year) 3-1048	Birthplace (State or Foreign Country)
ehow	Usuat Residence of Decedent 10a. State 10b. County		Town or Location	-		10d. Inside City Limits 1 12 Yes 2 □ No
r 28e-f r 28e-f r pour li	10e. Street and Number		altimore 101. Zip Code		10g. Citizen of What	
th with	11 W. 20TH Stree	t Apt. TN	21	218	US.	A
Pages 1 and 2 should be filed within 72 hours efter death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other then "neturel", or items 23e or 28e-f ehow ury or other treumetic event, it is Medical Examiner must be notified at ITO of the West of the Medical Examiner must be notified at ITO Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Xividowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ Ûo If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cubs 1 ☐ Yes 2又No	lispanic Origin? (Specify Yes o an, Mexican, Puerto Rican, etc. Specify:		merican Indian, hite, etc. BLACK
72 ho	15. Decedent's Edu (Specify only highest grade	cation	16a. Decedent's Usual Occup	ation	16b. Kind of Busine	ss/Industry
ed within 72 ho ygjene. her then "neture it, the Medical I	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired NUTSE		Health	, care
Mental Hy Mental Hy arked othe atic event	17. Father's Name (First, Middle, Last) Frances Brown	,		18. Mother's Name (First, Mic	ddle, Maiden Surname) SKCWIII	
permit. Pages 1 and 2 should be filed within 72 ho Department of Health end Mental Hygiene. Important: If Item 27 is marked other then "netun any injury or other treumetic event, the Macical once. To Be Completed	19a. Informant's Name/Relationship (Ty Pamcja Gilliam	/sister	34 Edgewoi	and Number or Rural Route No d Street Bo	umber, City or Town, State Altimore Mo	
Pages 1 nent of He ury or oth	20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State cem	ce of Disposition (Mame of netery, crematory or other place CEDU Hill	Date (02:05:1	20c. Location - City S Baltimo	
permit. Page Department of Important: If any injury or once.	21. Signature of Funeral Service License	ee	22. Name and Addres	ss of Facility Execut Fund	ral Services	
Cal Examiner	23a. Part1. Ent sche disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a		CLON (Approximate Interval Between Onset and Death
net the death certificate by the attending physicleched for use as the leteched for use as the Physiclan/Medica	resulting in death) Last					
by the destected	Part II. Other significant conditions con	tributing to death but not resulting	ng in the underlying cause give			Probably Unknown
The law requires the page 1 speed signed page 2 should be de Completed by I	Dialect	at he	eet		Vas an eutopsy 24 performed?	b. Were autopsy findings available prior to completion of cause of death?
The la	Carde	onjogo	Quy	1	□Yes ≱\no	1 □ Yes 25 No
To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours efter death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be deteched for use as the Medical Certification: To Be Completed by Physiclan/Medical	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death	28a. Date of Injury (Month, Day Year) 28		y at 28d. Descr k? Yes 2 No	Residence 6 □Other (S _i ibe how injury occurred	
tal or Att us efter d ral Direct lled in by	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)		City or	on (Street and Number or Town, State)	
the Hospit thin 24 hour the Funer mpletely fill	29a. Certifier (Check only one) 2 Medical Examir 29b. Signature and title of certifier	Iclan: To the best of my knowle ler: On the basis of examination and manner stated.	adge, death occurred at the tin a and/or investigation, in my o	pinion, death occurred at the ti	the cause(s) end manner me, date and place, and d 29d. Date signed (Mo	lue to the cause(s)
, <u>*</u> 6 8 - 5	How	B. G	han ori)) DZ168	i 3	si (05 -
H	30. Name and address of person who co	PARKI	te (CHTS	. 3VA.	2121	5
State Registrar	31. Date filed (Month, Day, Year) FEB 8 2005	2. Registrar's Signature	beds			

DHMH 16 Rev 6/95

			State of Maryland / Dep		•	A A A A	03658
			Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg. N		3. Time of Death
	Physici /Medic		MELVIH FRIEDMAN		Month	2005	5.40.P.M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death	
	Funeral		Northwest Hospital Conter 5401 Old Conter 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.		Baltimor. 9. Birthpla	ce (State or Foreign
	Director		215-09-6963 1 ¹ M 2□ F 90 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 11/25/1914	Country	MD
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation		100	d. Inside City Limits
	e Man 3a-f sh tiffied	ctor	MD BALTIMORE RANDALL	STOWN			1 ☐ Yes 2X No
	with th	Dire	10e. Street and Number 9003 SAMOSET ROAD	10f. Zip Code 21133	10g, C	itizen of What Country U.S.A.	y?
	death	nera		Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Department of Heatth and Mental Hygiene. If item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Madical Examinar must be notified at once.	by Funeral Director	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Hican, etc.)	Black, White, etc. Specify: WHIT	
21215-0036	"natur	leted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki	ng 16b.	Kind of Business/Indu	stry
212	s withir piene. r then	omp	Elementary/Secondary (0-12) College (1-4or 5+) PR	DO NOT use retired) OPRIETOR	(GROCERY STO	ORE
	be filled tal Hyg d othe event,	Be Completed	17. Father's Name (First, Middle, Last)		(First, Middle, Maide		
Maryland	should be find Mental to marked of	P	HARRY FRIEDM	AN REBECCA ng Address (Street and Number or Rura		EVIN	inde)
	and 2 s ealth an n 27 ls nar treu		I	3 SAMOSET ROAD RAN			000)
altimore,	Pages 1 and the part of the part: If item arry or other		1 2 Buriai 2 Li Cremation 3 Li Hemovai from State	matory or other place)		Location - City or Town	
<u>=</u>	artmen artmen ortent: injury		`4 □Donation 5 □Other (Specify) HAR SINAI	CONG. 02/06 2. Name and Address of Facility SOL		NGS MILLS	
Ba	permit. Departr Importa			900 REISTERSTOWN R			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac of	r respiratory arrest,	lr.	approximate nterval Between
- 3	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	homa			Onset and Death
3	Examiner		Due to (or as a consequence of):				
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)				
,	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
3760	ate be hysicia he bur	ical	d				
9 ×	leath certifica attending ph I for use as ti	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			02d Data of delivery	
O. Box	0 0 0	Physician/Med	in the past 12 months? 1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Da	
<u>.</u>	res that the de signed by the a l be detached i	by Phy	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
ords	w requires been sig should be		Atrial Herilahon		1 ☐ Yes 2	2 ☐ No 3 ☐ Probab	ly 4 Unknown
Records,	2 2 2	Completed			24a. Was an autopsy performed?	prior to comp death?	y findings available letion of cause of
Vita	sicien: The certificate ha	Be	25. Was case referred to medical examiner? Hospital: 4 T 4 T 4 T 4 T 5 T 5 T 5 T 5 T 5 T 5 T	26. Place of Death	(Check only one)		
ō	Physi r this o	5. To	27. Manner of Death 28a. Date of Injury 28b. Time o		ne 5 Residence		
ion	ttending P death. ctor: After y the funera	atior	1-∰Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division of Vital	el or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, steel building, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Stai	nd Number or Rural R te)	Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death To the Funeral Directors After this certification of the Funeral Directors and the funeral director,	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cause(sed at the time, date an	s) and manner as state and place, and due to th	ed. ne cause(s)
	To the Vithin To the comp	W	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Da	y, Year)
1	<		30. Name and address of person who completed cause of death (Item 23a) (Type,	D54288		Tebruary tap Carl	3 1005
3	1		Homogwany I Rangas	ofav. Morth	81 Hopen	lef leng	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 8 2005 32 Registrar's Signature	ale North			

				State of Maryland / C	Department of Health Certificate of Deatl	h	piene 2005	03659
		Physici		1. Decedent's Name (First, Middle, Last) BETTY E. GILES		2. Date of Deat Month	Day Year	3. Time of Death 6:05 a M
		/Medio Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location	February n of Death	7 5 , 2005 4c. County of Death	J 0.03 W
		F		HARFORD MEMORIAL HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birt	HAVRE DE GRA		HARFORD 9 Bight	
		Funeral Director		219-60-2947 1 M XX 5 57	rs. Months Days Hours		Year) Cour 1947 MAF	elace (State or Foreign htry) YLAND
		show ad at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		1	0d. Inside City Limits
		death with the Maryland ms 23e or 28a-f show (must be notified at	Director		ARLINGTON			1 ☐ Yes % No
		with th	Dire	10e. Street and Number	10f. Zip Code 21034	1	Og. Citizen of What Cour	ntry?
		r death	Funeral	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	Origin? (Specify Yes or No- can, Puerto Rican, etc.)	14. Race - Americ Black, White,	
	5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hyglene, item 27 is marked other then "naturel", or Items 23e or 28e.1 show other treumatic event, the Medical Examinat must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Mo 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specif		Specify: BLAC	
	15-0	"natur	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired)	ost of working	16b. Kind of Business/In	dustry
	2121	d within glene. or then "	omo	Elementary/Secondary (0-12) College (1-4or 5+) 12th grade	HOUSEKEEPING		APG	
35	and	2 should be filed withir and Mental Hyglene. is marked other then eumatic event, the Ma	Be	17. Father's Name (First, Middle, Last)		ther's Name (First, Middle, M	Maiden Sumame)	
10	Maryland	should ind Men ind marke	To	Joseph Akins 19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Num.	rtrude Akins aber or Rural Route Number	; City or Town, State, Zip	Code)
2/5	, M	and 2 ealth a m 27 is			203 Holloway Rd			
	nore	ages 1 int of H t: If ite y or otl		IXXBurial 2 ☐ Cremation 3 ☐ Removal from State cemeter	Disposition (Name of y, crematory or other place)		20c. Location - City or To	
	Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tre		21. Signature of Fyneral Service Licensee	EY CEMETERY 22. Name and Address of Fac WM C BROWN COM		OARLINGTON,	
		20529		234. Part1. Enter the disease, or complications that caused the death. Do n	321 S PHILADI	ELPHIA BLVD,	ABERDEEN, M	D 21001 Approximate
		Enysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Arteny D	es cardiacon respiratory arre	- S	Interval Between Onset and Death
2		/Medical Examiner		resulting in death) a. Due to (or as a consequence of	f):			3 413
Mithan			Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	#: ()			3 /2
= 4	V	ecuted and I-transit	Examiner	Cause (Disease or injury that initiated events c	A)			
5	Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burral-transit	calE	d				
02	x 68	entification ding physical as the		IF FEMALE: 23c. If yes, outcome of pregnancy				
	Bo.	that the death certifica ed by the attending ph detached for use as ti	Physician/Med	in the past 12 months? 1 \[\text{Live birth} \ 2 \] \[\text{Fetal death} \] 1 \[\text{Vas} \] 4 \[\text{Pregnant at time of death} \]	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	Day Year
	P.O.	hat the d by th fetache		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part	+ I 23a Did tok	pacco use contribute to the	ne cause of death?
	Records,	quires that n signed l	d by	Renai feuline, Dialelin	Melilies	1 🗆 Ye	L.F	ably 4 Unknown
	ecol	ie law requii has been s je 2 should	ompleted	Probable Sephs die	CT Seven	24a. Was au	v prior to con	psy findings available inpletion of cause of
7	al B		O	granvitis		perforn	ned? death?	2 No
#	f Vital	ysicier is certif directo	o Be	25. Was cale referred to medical examiner? 1 □ Yes 2 No Hospital: 1 Inpatient 2 □ EP/Out	Othor	ce of Death (Check only one Nursing Home 5 Reside		()
3	n of	ding Physicien: The h. h. After this certificate ha funeral director, page	lon: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. T	ime of 28c. Injury at ijury Work?	28d. Describe ho	ow injury occurred	,
8	Division	or Attending Physicien: ifter death. Director: After this certific in by the funeral director,	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building etc. (Specify)	M 1 ☐ Yes 2 ☐ m, street, factory, office	28f. Location (Str	reet and Number or Rura	l Route Number,
11	Ö	urs afte rral Dire	0	55		City or Town		
9		To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the bast of my knowledge 2 Medical Examiner: On the basts of examination and and manner stated.	death occurred at the time, date a for investigation, in my opinion, de	and place, and due to the ca eath occurred at the time, da	ause(s) and manner as si ate and place, and due to	ated. the cause(s)
		To th withir To th comp	M	29b. Signature and title of certifier MD	29c. License number		9d. Date signed (Month,	Day, Year)
		/		30 Name and address of person 100 completed cause of death (Item 23a) (19326 Type, Print)		45/05	
		2		Kammaden Melisani MD 1106	Revolution St	Meure De la	race 1/10 i	11078
		Sta Registi		FER () 8 200F	his is			
	DH	MH 17 Rev 1/2	001		A CONTRACTOR OF THE PARTY OF TH			
				ORIG	INAL			

State of Maryland / Department of Health and Mental Hygiene 15 03660 = For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** February 2005 3:00 A Mary Ruby Dorothy Geiman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore 4925 Sinclair Lane If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 17, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 ☐ M 2 🕱 F Dec. 80 Yrs. England Director 213-28-4200 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Director Baltimore Maryland N/A10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number S. A. Items 23a 4925 Sinclair Lane 21206 Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 5 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 White 3 Widowed 4 □ Divorced 'natural', 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) in track betting/ al Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) lottery Chief Inspector 12th Grade .. Pages 1 and 2 should be filed vitnent of Health and Mental Hygie tant: If item 27 is marked other taury or other traumatic event, IL. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frances Agnes McGough ို Ernest Griffin Fleming 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4925 Sinclair Lane, Baltimore, Maryland 21206 Frances Shrader (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖒 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 02/07/2005 Baltimore, Maryland Bauview Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final THEROJLERUSIN OVOWA **Physician** resulting in death) /Medical Due to or as a consequence of): **Examiner** JE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medlcai IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnapt 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Month for in the past 12 months 5 Other (specify) ☐Yes 2 No P.0. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, page 2 should be 3 Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 2 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Phospital or Attending Place Hours after death.

Puneral Director: After the Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide 4 Homicide I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Pay, Year) 29b. Signatur and title of certified 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 206 Good Samaritan Hospital, 5601 Loch Raven Blvd., Balto, Md. 21239 Gerald Insel. 2. Registrar's Sign State Registrar

		. •	1 - State of Maryland / Department	artment of Health and Martificate of Death		ene N2 005 03661
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Edna Mae	Guyton	2. Date of Death Month FEDRUARY	Day Year 3:25 P M
	Examin		4a. Facility Name (If not institution, give street and number) 800 OLD HEARLD HARBOR RD	4b. City, Town, or Location of Death CROWNSVILLE	1	4c. County of Death ANNE ARUNDEL CO
	Funeral Director		5. Social Security Number 216-14-5130 6. Sex 1 M 2 K F 84 Yrs. last birthday)	ff Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day Y March 7,	(ear) 9. Birthplace (State or Foreign Country) Maryland
	faryland show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo Maryland Anne Arundel Crownsvil.	_		10d. Inside City Limits 1 ☐ Yes 2 No
	with the N 3a or 28a-	Director	10e. Street and Number 800 Old Herald Harbor Road	10f. Zip Code 21032		p. Citizen of What Country?
980	4 within 72 hours after death with the Maryland liene. I than "natural", or Items 23a or 28a-1 show the Modical Examiner must be notified at	by Funeral	11. Maritat Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 Alo	Was Decedent of Hispanic Origin? (Si f Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	pecify Yes or No-	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	within ene. than "	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired) Army Finance	king	Sb. Kind of Business/Industry Government
/land	be filed trail Hyg of othe event,	To Be C	17. Father's Name (First, Middle, Last) Stonewall J. Beall		ne (First, Middle, Ma Mae Brunn	
	nd 2 alth at 27 ls		19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	ng Address (Street and Number or Ru D4 Songwood Court		
Baltimore,	Pages nent or ant: If Irry or		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Soojcify) 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 4 ☐ Donation 5 ☐ Other (Soojcify)	sition (Name of natory or other place) Memorial rdens		Anniap 8715, Mb Second Ave. S.W.
Ba	permit. Departr Imports any inju		MC 1901411 SE			.Glen Burnie, MD 2106.
58760,	Physician /Medical Examiner physician and physician and physician and physician and physician site price is the price of the physician and phy	edical Examiner	23a. Part 1. Enter the disase, or complications that caused the death. Do not entry shock, or heart laily. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Last Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	•		Onset and Death
.O. Box 6	The law requires that the death certific tie has been signed by the attending prage 2 should be detached for use as	Physician/Me		Ectopic pregnancy Other (specify)	-	23d. Date of delivery Month Day Year
٥	quires that in signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		cco use contribute to the cause of death?
al Records,		Completed			24a. Was an autopsy performe 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?
sion of Vital	Attending Physicien: J death. ctor: After this certifical y the funeral director, p	atlon: To Be	25. Was case referred to medical examiner? **Was 2 \subseteq No** 27. Manner of Death 1 \subseteq Natural 5 \subseteq Pending investigation 28b. Time of Injury (Month, Day Year) 1 \subseteq Natural 2 \subseteq Accident 28b. Time of Injury (Month, Day Year) 1 \subseteq Natural 2 \su	ot 3 DOA Other: 4 Nursing H	28d. Describe how	ce 6 XOther (Specify) SCENE injury occurred
Division	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Medical Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, strn building, etc. (Specify) Parallel Certifier (Check only one) 29a. Certifier (Check only one) 28e. Place of Injury - At home, farm, strn building, etc. (Specify) Parallel Certifying Physician: To the best of my knowledge, death and manner stated.	RESIDENCE	800 OLD HEDA	DUD FHARD DERD A COUNTY
	To the within: To the comple	Mec	29b. Signature and title of certifier Maybe The Yall M	29c. License number O C M E		EBRUARY 6, 2005
	Sta		30. Name and address of person who completed cause of death (Item 23a) (Type, H N N N N N N N N N N N N N N N N N N	111 PENN STREE	T, BALTIM	ORE, MARYLAND, 21201
	Registi	ar	FEB 0 8 2005 And & Spark	ED.		

			1 - For State Registrar	State of Marylan	d / Depa	artment of H	ealth and N	-	ene	
			Registrar 1. Decedent's Name (First, Middle, La.	stl	Cei	rtificate of L	Jeath	Re-	2005	0 3 6 6 2 3. Time of Death
	Physici		DOROTHEA	G	RAH	tE		Month FEBRUAR)	Day Year	11 4 60
	/Medic Examin		4a. Facility Name (If not institution, giv		_	4b. City, Town, or	Location of Death		4c. County of De	
				ITAL CENTE			IMORE			
П	Funeral Director		5. Social Security Number 6. S 212–28–0658	ex 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jul 30,	Year) (irthplace (State or Foreign Country)
	טי		Usual Residence of Decedent					Jul 30,	1930 ML	
	ehow	'n	10a. State 10b. County		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	Funeral Director	MD Anne A	rundel Li	nthicu	10f. Zip Code		10	g. Citizen of What (
	h with	ID Is	305 South Camp Mo	eade Road		21090	0		U.S.A.	
	ems ?	ner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi		pecify Yes or No-	14. Race - An Black, Wh	nerican Indian,
36	72 hours after death with the Maryland natural; or Items 23a or 28e-f ehow lical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married X 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give X Year or Dates:		1 ☐ Yes 2 🛣 No		, , , , , , , , , , , , , , , , , , , ,		white
9	2 hour		15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	ation	10	6b. Kind of Busines	s/Industry
215	within 7. iene. then "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give life.	kind of work done d DO NOT use retired,	furing most of worl)	king		
21	e filed wi Il Hygien othar th vant, the		6 17. Father's Name (First, Middle, Last,		Sa:	les	40. 14-45-4-11-	- (Fina Middle M	Montgome	ry Wards
Maryland 21215-0036	ild be fi lental H kad ot Ic evar	To Be	"unknown"	1				ne <i>(First, Middl</i> e, <i>M</i> mma K i sse	100	
aryl	shoul and Me s mark umatl	Ĕ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a				Zip Code)
	and 2 salth a n 27 le		Mr. George Grahe,			South Camp			thicum, M	D 21090
Baltimore,	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Health and Mental Hygiene. ortant: If Itam 27 is marked othar then "natural; or Items 23a or 28e-f show injury or othar traumatic evant, the Micrial Examiner must be notified at injury or othar traumatic evant, the Micrial Examiner must be notified at 9.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Tuenioval ilolii State		sition (Name of matory or other place			Oc. Location - City of	
Him	permit. Page Department of Important: If any injury or once.		'4 ☐ Donation 5 ☐ Other (Specification of the Company of the Property of the Company of the Com			11 Cemete: 2 Name and Addres				
Ba	permi Depa Impo any ir		This out	Vin MO131	0	Second A				
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat one cause on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. VENTRIC Due to (or as a conseq	ULAR	TACK	HYCAR	DIA		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	MEDUA	INDATI	1 V		201.
		Jer	Sequentially list conditions, if any, leading to immediate	b. HYPOXIC Due to (or as a conseq	uence of):	VCEPAHI	LUPTIF	7 9		aanrs
V	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ISCHEM	10	BOWEL	DISE	FASE		22 hrs.
,092	be execian a	cal Ex	resulting in death) Last	Due to (or as a conseq	uence of):					
687	3 % 8	edlo		d						
Вох	death certificat e attending phy d for use as th	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			23d. Date of d	elivery
	0 0 0	Physician/M	in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	4☐ Pregnant at time of d		Other (specify)			Month	Day Year
P.0	that the de led by the a detached t		Part II. Other significant conditions of	contributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
Records,	og De	d by	HYPERTENS	ION				1 ☐ Yes	2 ⊠ No 3 □ F	Probably 4 Unknown
000	e law requir has been si je 2 should	ompleted						24a. Was an autopsy		autopsy findings available completion of cause of
E Re		Com						performe	ed? death?	
Vital	Phyalcian: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:		Othe	NC.	th (Check only one,		
of	Phys rthis ral di	To To	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of	f 28c. Injury	at Nursing Fig	ome 5 Residen 28d. Describe how	ce 6 Other (Sp	ecify)
ion	Attanding Ph r death. actor: After thi by the funeral	atlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work	(? Yes 2 □ No			
Division		Certification:	3 Suicide 6 Could not be determined		ome, farm, str	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	Hospital or thours afte Funaral Dir tely filled in		29a. Certifier 1 🔀 Certifying Ph	hydinion. To the heat of my kee	udodoo dootti					
	To the Hospital or within 24 hours after To the Funaral Dir completely filled in	edical	(Check only one)	nysicien: To the best of my kno niner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my op	pinion, death occur	red at the time, dat	e and place, and du	is stated. lie to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	1500000		29c. License			d. Date signed (Mor	
			▶ Karima							
	(0		30. Name and address of person who KARUNA POSAN	completed cause of death (Iten 1 3001 SOUTH 32. Registrar's Signa	1 23a) (Type,	Print) VOVER S	TREET.	BALTIME	ORE, MI	D 21225
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	-6				
1	Registr	ar	FFR 0 8 20	95 Janes &	y do	ve				

		•	1 - For State Registrar	State of	Marylan		artmen rtificate				ental Hy	giene Reg. No	-)	036	63
			1. Decedent's Name (First, Middle,	Last)							2. Date of Dea	ath			3. Time of	Death
	Physici /Medic		CLEO PATRICK	GIBBS							Month FEBRUAR	Y 2			06:30) P ^M
	Examin		4a. Facility Name (If not institution,		-		4b. City,	Town, or	Location	of Death		4c.	County of [Death		
			Mariner Health				Glen						Anne A			
	Funeral Director		5. Social Security Number 168–20–7104	5. Sex 7 1 □ M 2 ☐ F	. Age (In yrs. I 84	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt. (Month, Day 11/14/	h v. <i>Year)</i> 1920			lace (State of etry) 1 Caro]	
			Usual Residence of Decedent				1				11/17/	1720	De	, a Li	i daro.	LIIIa
	h the Maryland r 28e-f show	_	10a. State 10b. County		10c. City	, Town or Lo	ocation							1	0d. Inside Cit	
	8e-f s	cto	Maryland Anne A	rundel	Se	vern	·								1 🗌 Yes	2 <u>M</u> No
	with the Maryland a or 28e-f show	Funeral Director	10e. Street and Number				10f. Zip						izen of Wha	t Coun	itry?	
	death w	rai	518 Queenstown		ant Free in III	C 10		L44	:i- Osi	i=i=0 /C==	-4	USA	14. Race - /	A /	an Indian	
		'n	11. Marital Status 1 □ Never Married 2 □ Marrie	12. Was Deced Armed Ford d 1 ☐ Yes 2	ent Ever in U. es? DE No	5. 13.	If Yes, spec	ify Cuba	in, Mexicar	i, Puerto	cify Yes or No- Rican, etc.)		Black, V			
336		by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dat			1 ☐ Yes 2	2X No	Specify:				Specify:	B1a	ıck	
9	72 hours "natural",	Completed	15. Decedent's	Education		16a. Dece	dent's Usua	I Occup	ation	A - 4	. 1	16b. K	ind of Busine	ess/Inc	dustry	
215		pie	(Specify only highest Elementary/Secondary (0-12)	College (1-4	for 5+)		kind of wor DO NOT us			t or worki	ng	_				
2	filed wi Hygien ather th	Con	12	N/A		Dome	estic	Wor.					lepend	ent		
pu	d at a	Be	17. Father's Name (First, Middle, L.		D	. 1					(First, Middle,					
Σ	ould b	10		Ε.	Byr	-				icto		inco				
Maryland 21215-0036	ges 1 and 2 should it of Health and Men if item 27 is marke or other treumetic		19a. Informant's Name/Relationshi								<i>i R</i> oute Numbe , Mary1	-			Code)	
	ss 1 and 2 of Health item 27 I		20a. Method of Disposition		20b. P						ate		cation - City		wn State	
Baltimore,	ages nt of l		1 X Burial 2 Cremation		ale	lace of Dispo emetery, crei			⁽⁹⁾ F	ebru'	arv 8.					
臣	permit. Pages Department of Importent: If i any injury or once.		 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lieuway) 		St.	Rest			s of Facilit	20 V Cđ.			rn, M	-		
Ba	permit. Departr Imports any inj		PR HO	2/ 1	M00303	1	Secor	id A	ve. S	W	gleton Glen B	rune urn i	eral H	ome 21	061	
	9		23a. Part1. Enter the diseas, or o	omplic flions that cau	used the death			100					,	T	Approximate)
M	Physician		shock, or heart failure. List o Immediate Cause (Final	CHR		0 6	FN	IAI	=	AII	URE			12	Onset and D	een C
	/Medical		disease or condition resulting in death)	a	rasa consequ			, , , ,	- \ /	,,,,	-			-	3 / 1	<u></u>
	Examiner			ESS	アドハ。	TIA	L	44	PEI	RT	ENIS	10	N	1	5YE	ARS
7	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	r as a consequ			1)		. n C			•	-	2 / 1 / 12	-4 01
V	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· D1141	DETI		ME	LL	LT	V S	2			4	-971	JAK.
90,	oe execian a	EX	resulting in death) cast	Due to (or	r as a consequ	uence of):										
8760	ate hys	dicai		d										-		
9 ×		- w	IF FEMALE:	23c. If yes, outco	ome of pregna	ncv					· ·		204 D-11	4 - 15		
Вох	death certifi e attending d for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bin	th 2 Fetal	death 3	Ectopic pro						23d. Date of Month		-	ear
o.	0 0 0	ysi	1 □ Yes 2 ◘ No 9 □ Unknown	9□ Unknov		Jan. 02	2 Out of (ab)									
0	requires that the een signed by th nould be detache	by Pr	Part II. Other significant condition	s contributing to dea	th but not resu	ulting in the u	nderlying ca	ause grve	en in Part I		23e. Did to	bacco u	ise contribut	e to th	e cause of de	eath?
Records,	n sign	d be	HEPATI	FIS	$\mathcal{C}_{\underline{\underline{\underline{\underline{\underline{\underline{\underline{\underline{\underline{\underline{\underline{\underline{\underline{\underline{\underline{\underline{\underline{\underline$						1□Y	es 2	No 3] Proba	ably 4 🗆 U	nknown
9		Completed									24a. Was a		34b. Were	autop	sy findings a	vailable
Re	The law ate has b page 2 s	шо									autop: perfor	sy med? 2 No	deat	h?	npletion of ca 2□ No	use of
Vital	(0) 1-4	0	25. Was case referred to medical						26. Place	Death	(Check only or		1	103	26,140	
>		To B	examiner?	Hospital: 1 🗆 Ing	patient 2	ER/Outpatier	nt 3□ DO	A Oth	er: 4 Nu	irsing Hor	ne 5 Resid	ence (6 ☐Other (5	Specify)	
n of			27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time o	2	8c. Injury Work	at	- 2	28d. Describe h	ow injur	y occurred			
Sio		atic	2 Accident investiga				М		Yes 2	No						
Division	or Att ter de irecto	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 28e. Place o	f Injury - At ho g, etc. (Specify	me, farm, str	eet, factory	, office		2	28f. Location (S City or Tow	treet an n, State	d Number o	r Rural	Route Numb	er,
	urs af															
	Hosp 24 ho Fune Fune	Medical	29a. Certifier 1 ☐ Certifying (Check only 2 ☐ Medical E	Physicien: To the base xaminer: On the base and manner	is of examinal	wledge, deat tion and/or in	n occurred a vestigation,	at the tim in my of	ne, date an pinion, dea	d place, a th occurre	and due to the o ad at the time, o	ause(s) date and	and manne place, and	r as sta due to	ated. the cause(s)	
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Mec	29b. Signature and title of certifier	1 C D	n stated.		29c	. License	number		1 2	29d. Dat	e signed (M	onth, E	Day, Year)	
	F ≥ F ŏ		> Start	migh	- M	0		D	14	16	0 f	-EI	3 RVI	AR'	107.	200.
	, (30 N m And address brourson w	Q complete cause	of death (Hem	23a) (Type	Printh -	A	RIT	-0 LJ	IF III	CH	W/AU	1	SAIT	TOLOG
	4	9 1	TIMOIT .	> (149 H	(141.77	. 5	MA	RY1	AA		2 17	21	1	2	DITTI	ון עוציון
	Sta	te	31. Date filed (Month, Day, Year)	22. Rec	gistrar's Signa	ture	M.		-114	1-1-1			2			

	1	For State Registrar	State of N	lary lan		rtment c				giene Reg. No.	005	03664
Physiciar /Medica	1	1. Decedent's Name (First, Middle, Last) ROBERT	GARD	NER					2. Date of De Month FEB	ath Day	SOO? Aeet	3. Time of Death
Examine	Í	/ / / / / / / / / / / / / / / / / / / /	Y GENA	NAL H			Ungi	A		i	tow AR	5
Funeral Director		214-10-5570	M 2□F	Age (In yrs. 83	last birthday) Yrs.	If Under 1 Y Months D	ays Hou	der 24 Hrs. rs Min.	8. Date of Bir 9—14—2	Year)	9. Bin	hplace (State or Foreign untry) MD
death with the Maryland ms 23s or 28s-f show		Usual Residence of Decedent 10a. State 10b. County MD CARROLI		10c. City	y, Town or Loc West	ation minste	r					10d. Inside City Limits 1 ☐ Yes 2 🖔 No
with the	Funeral Director	10e. Street and Number 987 Wilda Drive		1		10f. Zip Co	1157			10g. Citiz	en of What Co USA	ountry?
e = = =	by Funera	11. Marital Status 1 □ Never Married 2 □ Married 3 ※ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1 X Yes 2 [If Yes, Give Year or Date:	s?] No	lf	Vas Decedent Yes, specify	Cuban, Mex	ican, Puerto	ecify Yes or No Rican, etc.)		4. Race - Ame Black, Whit Specify: W	e, etc.
d within 72 hours af giene. ar than "natural", or the Medical Exam	Completed	15. Decedent's Education (Specify only highest grad	cation e completed) College (1-4c	or 5+)	(Give I	ent's Usual O kind of work a OO NOT use r ement	lone <i>durin</i> g r etired)		ing	16b. Kind of Business/Industry Government		
Id be filed vental Hygie kad othar tic avant, Ib	To Be Co	17. Father's Name (First, Middle, Last) Ernest	Gai	dner	8		18. M		e (First, Middle	, Maiden S ene	Sumame) Cri	.st
nd 2 should be file alth and Mental Hy 27 Is marked oth r traumatic avant		19a. Informant's Name/Relationship (7) Mrs. Susan L. Ryde		er					al Route Numb			Zip Code)
permit. Pages 1 and 2 should be permit. Pages 1 and 2 should be permit of Health and Menta Important: If itam 27 Is marked any injury or other traumatic and once.		20a. Method of Disposition 1 A Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)		. ! .	Place of Disposemetery, crem adowrid	ge Mem	rplace) norial	2/5) 2005	E1kr:	-	D
permit. Departrimports any inju		21. Signature of Funeral Service Lioyn,	2	M0136	1	Second	d Ave	SW Gle	ngleton en Burn	ie MI	ral Ho 21061	ne P.A.
Pnysician /Medical Examiner	-	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or END Due to (or Due to (or	as a consequence of the conseque	uence of): F Q quence of):	ENM	DISEA	ASE				Interval Between Onset and Death
	lical Examiner										AJÉ	
is that the death certific igned by the attending p be detached for use as is	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnan 9 □ Unknowi	1 2 ☐ Feta t at time of c	aldeath 3	Ectopic pregi Other (speci				2	3d. Date of de Month	livery Day Year
Lay T.		Part II. Other significant conditions co	ntributing to deat	h but not res	sulting in the u	nderlying caus	se given in P	art I.			se contribute t ∃No 3⊟P	o the cause of death? robably 4 Unknown
VIIdi MECOIDS, sicien: The law requires th certificate has been signe rector, page 2 should be c	Completed			-					24a. Was auto perfi 1 \(\text{Yes}		prior to death?	utopsy findings available completion of cause of
ing Physician: The later this certificate hauneral director, page	To Be	27. Manner of Death 1 Natural 5 Pending	28a. Date of I		ER/Outpatier 28b. Time of Injury		Othor	☐ Nursing Ho	th (Check only ome 5 Res 28d. Describe	idence 6		ocify)
To the Hospital or Attanding Physwithin 24 hours after death. To tha Funaral Diractor: After this completely filled in by the funeral director.	Certification:	*2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building	Injury - At h , etc. (Speci	nome, farm, str fy)		-		28f. Location City or To	(Street and wn, State)	d Number or R	ural Route Number,
To the Hospital or within 24 hours after To tha Funaral Dirt completely filled in	Medical C	29a. Certifier (Check only one) 2 Medical Exam	rsician: To the be iner: On the basi and manner	s of examina	owledge, deatl ation and/or in	vestigation, in	the time, dat my opinion, icense num	, death occur	and due to the red at the time	, date and	and manner a place, and du	e to the cause(s)
To with To com	2	29b. Signature and title of certifier	ATTEN		m 22a) /*	4	00056			I-G	20	
(p	20	30. Name and address of person who of the state of the st	INDA	(77)	I M.LEV	NLEAP	Cour	1 45	24 Co	LUMB	SA NO	21045
Registra	9 24	FEB 0 8 2005	32. Reg	s St.	gase							

S	-oode			State of Maryland / Department of Health and Mental Hygiene	
			For Stata	Contilions of Dooth	03665
			Registrar 1. Decedent's Name (First, Middle, I		3. Time of Death
	Physicia	an	F.I. L.I.S	C. GOODE February 02, Year 2009	
	/Medic		4a. Facility Name (If not institution, g		12:20 P
	Examin	er	962 North Hill 1		MODE
	Europol			S. Sex , 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthp	lace (State or Foreign
	Funeral Director		215-40-3136	10 M 2 F (22 Yrs. Months Days Hours Min. (Month, Day, Year)	EVLAND
	p		Usual Residence of Decedent		
	nylar show	_	10a. State 10b. County		0d. Inside City Limits 1
	Ba-f	cto		TIMORE BALTIMORE	
	death with the Maryland ms 23a or 28a-f show rmust be notified at	Funeral Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Cour	ntry?
	s 23g	rai	962 NOR		H.
	ter de Itam Itam	un.	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White,	
38	hours after tural', or Ita	by	3 Widowed 4 Divorced	If Yes, Give 1 ☐ Yes 2 1 ▼ No Specify: Specify: Specify:	AC.K
5-0036	72 hou		15. Decedent's	Education 16a. Decedent's Usual Occupation 16b. Kind of Business/In	dustry
215	within 7 ene. than "n	pie	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5+) life. DO NOT use retired)	~~~
2	ed wil /gien er th	Completed	12th	MACHINIST BETH	> 1666
p	be filk tal Hy d oth	To Be	17. Father's Name (First, Middle, La		
<u>yla</u>	2 should be filed withir and Mental Hygiene. Is marked other than aumatic avant, ITA M	ို	KUBEKT	GOODE HATTIE BUFORD	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar f Health and Mental Hyglene. I the marked other than "natural", or Itams 23a or 28a-f show other traumatic avant. If a Medical Evarial or mast be notified at		19a. Informant's Name/Relationship		
	os 1 and 20 Health itam 27 other tr		20a. Method of Disposition	20b. Place of Disposition (Name of Date 20c. Location - City or To	
ğ	m O		1 Burial 2 Cremation 3		
Baltimore,	permit. Page Department and Important: If any injury or any injury or once.	- 3	* 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lice	icensee 22. Name and Address of Faulty / DFMATINA CET	NO FO
Ba	permi Depa Impo any ii		132 Cl-	GREENMOUNT CREMINAL 2.5.05 BALTIMORE NATIONAL PIKE	BALTOMO21725
	-		23a. Part1. Enter the disease, or co	complications that ceused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest.	Approximate Interval Between
	Priysician		shock, or heart failure. List on Immediate Cause (Final		Onset and Death
	/Medical		disease or condition resulting in death)	a Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of):	
М	Examiner		Sequentially list conditions	b	
,-	р <u>;</u>	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):	
1	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):	
8760,	ate be executed nysician and he burial-transit			Suc to (of as a consequence on).	
687	0 0	edicai		d.	
Box (leath certifical attending phy I for use as th	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 23d. Date of delive	erv
ĕ	death atter	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Day Year
0	uires that the de signed by the a d be detached f	Physician/M	9 Unknown	9□ Unknown	
٥.	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions	ns contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the	ne cause of death?
ğ	w require been sig should b	ed 1		1 ☐ Yes 2 No 3 ☐ Prob	ably 4 □Unknown
Records,	> 10 m	ompieted		24a. Was an autopsy 24b. Were	psy findings available mpletion of cause of
E.	The law cate has page 2 :	Con		performed? death?	2 No
of Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
of \	Physi this o	은	1 XYes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 the (Specification of the Control of the Contr	W SCENE
n C	ding F	ion	1 XNatural 5 ☐ Pending		
Division	at to e	ical	2 Accident investigat 3 Suicide 6 Could no	of be and Place of Living. At home form street feeters effice.	il Route Number.
Ď	Jor A after Dira	Certification;	4 Homicide determina	building, etc. (Specify) City or Town, State)	
	Hospital 4 hours a Funaral tely filled			Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as s	
	To the Hospital or Atta within 24 hours after de To tha Funaral Diracto completely filled in by th	Medicai	(Check only 2 Medical Ex	xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated.	the cause(s)
	To th Withir To th	ž	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month,	Day, Year)
			1/ / / And	O.C.M.E. February 03,	2005
	ih			who completed cause of death (Item 23a) (Type, Print)	
	IU		J. Laron Locke,		
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrat's Signature	
	ricgisti	ш.	red 0	0 8 2005 Decemen de Sparke	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 11:59 AM February 2005 amela /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randallstown
If Under 1 Year | If Under 24 Hrs. Hospital Northwest Center 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 217-80-8841 Usual Residence of Decedent 1□M 201F **Director** Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. In a new 14 years and 14 stem 27 is marked other than "natural" or Items 23a or 28a-f show and 14 stem 27 is marked other than "natural" or other traumatic event. It a Medical Examinal must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? talls 16 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status t ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ø No Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. RO NOT use etired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 29llege (1-4or 5+) 2 Y/S 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Nellie Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trat once. Fails Chapel Husbard 6 Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 10-05 ◆ ■ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Vaughn C 22. Name and Address of Facility Greene Funeral Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Gastrointesti 10-20 minute /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading Limmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Tes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an 21 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 1 ☐ Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: A 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) ,2005 D28462 Februar Y 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Northwest Randallstown Maryland Hospita Baston enter 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

			1- State of Maryland / Departr Certifit State of Maryland / Departr	ment of Health and M icate of Death		ene 005	03667		
	Physici		Decedent's Name (First, Middle, Last) Jerome G. Grace		2. Date of Death 02-05-20	Bay Year	3. Time of Death 2:35 A M		
	/Medio Examin		4a. Facility Name (If not institution, give street and number) 4b.	. City, Town, or Location of Death		4c. County of Dea			
	LAGITIT		Charlestown Retirement Comm.	Catonsville		Baltimo	re.		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If	Under 1 Year If Under 24 Hrs.	8. Date of Birth		thplace (State or Foreign		
	Director		217 22 9968 125M 2 F 93 Yrs. Mo	onths Days Hours Min.	(Month, Day, Yi 03-06-191	$\stackrel{\theta ar)}{1} \stackrel{C}{\operatorname{Mai}}$	cyland		
	Ъ		Usual Residence of Decedent						
	nylan how		10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits		
	a-f.s	cto	MD Baltimore Arbutus				1 ☐ Yes 2 No		
	17 th	Director	10e. Street and Number	Of. Zip Code	10g	. Citizen of What C	ountry? •		
	15 wi	al	1313 Maple Avenue	21227	U	ISA			
	dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces? 13. Was	Decedent of Hispanic Origin? (Spe s, specify Cuban, Mexican, Puerto f	cify Yes or No-	14. Race - Am			
ဖွ	or ite		1 Never Married 2 Married 1 Yes 2 No	Yes 2 No Specify:	rican, etc.)	Black, Whi			
93	72 hours after death with the Maryland Ineturel; or Items 23e or 28e-f show dical Exartainer oust be notified at	d by	3 Widowed 4 Divorced Year or Dates:	165 ZENIO Specily.		Specify: VVII.	ice		
5-(I within 72 hours after death with the Marylan lien. Then: "neturel; or items 23e or 28e-1 show The Madical Examiner rust by notified at	Completed	(Specify only highest grade completed) (Give kind	s Usual Occupation of work done during most of working	16	b. Kind of Business	/Industry		
21	within ene. then "	Idu	Elementary/Secondary (0-12) College (1-4or 5+)	VOT use retired)					
2	e filed within al Hygiene. I other then vent, Lie we	S		ing Contractor		Own Bus	siness		
Maryland 21215-0036		Be	17. Father's Name (First, Middle, Last) George Thomas Grace	18. Mother's Name Mary Ceci		· · · · · · · · · · · · · · · · · · ·			
Ž	s 1 and 2 should be f f Health and Mental I item 27 is marked of other treumatic eve	ļ.		ddress (Street and Number or Rura			Zin Coda)		
Ma	d2s than 7 is i			pplar Avenue, Bal			ZIP Code)		
Ġ	is 1 and 2 of Health a item 27 is other tree			_		c. Location - City or	Town, State		
Baltimore,	0 0		1 Durial 2 Cremation 3 Removal from State	ry or other place)	30				
Ē	permit. Pag Department Importent: Imy injury conce.	14		me and Address of Facility Gary		lkridge,			
Ba	permit. Pag Department Importent: I any injury o	, 15	1/5/(. Helloman 7250	dowridge Memoria Washington Blvd	l Park 1., Elkri	dge, MD 2	21075		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.		r respiratory arrest		Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	nia			Onset and Death		
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				7		
	LAGITITICI		Sequentially list conditions, b.	list conditions, b. — Due to (or as a consequence of):					
	Si ad	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
	and I-tran	Examiner	resulting in death) Last C. Due to (or as a consequence of):		_				
8760,	ate be executed hysician and the burial-transit	al E	Substitution of the substi				19		
87	a + =	Physician/Medical	d						
9 ×	eath certitic attending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			201 0			
Вох	atten for us	ian	in the past 12 months?	opic pregnancy ser (specify)		23d. Date of de Month	Day Year		
o.	at the de by the tached	ysic	1 Yes 2 No 9 Unknown	er (specify)					
σ.	that the bed by detail		Part II. Other significant conditions contributing to death but not resulting in the under	ying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?		
of Vital Records,	gr gr	d by			1 Tes	2 □ No 3 □ P	obably 42 Unknown		
ÿ	w requir been si should	ete			240 1460 00	Odb Wass a			
3e(has has ge 2	Completed			24a. Was an autopsy performer	prior to	itopsy findings available completion of cause of		
a					1□ Yes 2₺	LNo 1 ☐ Yes	2□ No		
Vit	. Se G	Be	25. Was case referred to medical examiner?	26. Place of Death Other Nursing Hor					
of	Phys this ral dii	6	1 Inpatient 2 ER/Outpatient 3	The second of th	ne 5 ☐ Residence 8d. Describe how i	e 6 □Other (Spe	cify)		
nc	ling After fune	lon		28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	od. Describe now	injury occurred	•		
Si	Attending r death. sctor: After by the fune	ica	3 Suicide 6 Could not be Ose Bloss of Injury. At home form street 6		Rf Location /Stree	t and Number or Ri	iral Pouta Number		
Division		ertification;	4 Homicide determined building, etc. (Specify)	actory, onice	City or Town, S	itate)	nai Noute Number,		
_	e Hospital 24 hours a E Funerel letely filled	0	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ	turred at the time, date and place, a	nd due to the caus	e(s) and manner as	stated.		
	To the Hospital or within 24 hours atte To the Funerel Director Completely filled in the Funerel Completely filled in the Fune	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigand manner stated.	gation, in my opinion, death occurre	d at the time, date	and place, and due	to the cause(s)		
	To the lead that within 2 to the lead to t	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Mont	h, Day, Year)		
			M MM	ウインイイン	Fe	brian 5	2065		
	\mathcal{O}_{i}		30. Name and address of person who completed cause of death (Item 23a) (Type, Print))		Mayler.	/		
	\		And Geris 711 maid Choice	Lane Catasi	ile V	Mayla.			
	* Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature			- V			
	Registr	ar	FEB 0 8 2005						

		-	For State Registrar			d / Depa		lealth and N	Mental Hygi	•	03668	
	Physicia /Medic		1. Decedent's Name (First, Middle, La: SHEILA	m.			HIL	L	2. Date of Death Month FEBRUARY	Day Year		
	Examin	er	4a. Facility Name (If not institution, give THE JOHNS HOPKIN				BALTIM	CRE CI	TY	4c. County of Dea		
	Funeral Director		218-44-0002	9x 7. □ M 2 X F	Age (In yrs. Ia	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1) 2-27-4	9. Bi 16 Ba	rthplace (State or Foreign Country) Lltimore, Md.	
	72 hours after death with the Marylend "naturel", or items 23e or 28e-f show citical Examinat must be notified at	tor	Usual Residence of Decedent 10a. State 10b. County Md. N/A			Town or Local		-			10d. Inside City Limits 1 Yes 2 □ No	
	or 28a	Director	10e. Street and Number		De	LI CIM	10f. Zip Code		10	g. Citizen of What C	Country?	
	ns 23e	Funerai	4314 Parkside	12. Was Decede	ent Ever in U.S	S. 13. V	21206 Vas Decedent of H	ispanic Origin? (Sp in, Mexican, Puert		JSA 14. Race - Am	erican Indian,	
ð	or iter		1 Never Married 2 Married	Armed Force 1 ☐ Yes 2 If Yes, Give	No			ın, Mexican, Puerti Specify:	o Rican, etc.)	Black, Wh	ite, etc.	
2-0036		ted by	3 ☐ Widowed 4 ⚠ Divorced 15. Decedent's Ed	Year or Date	es:	16a, Deced	ent's Usual Occup	ation	11	6b. Kind of Busines:		
212	within 72 ene. than "nai	Completed	(Specify only highest gra	College (1-4	or 5+)	life. L	OO NOT use retired	,			G: A	
מ	filed Hygi ther	Be Co	12 17. Father's Name (First, Middle, Last)	4		Scho	ool Teac		ne (First, Middle, Mi	Baltimor aiden Sumame)	e City	
Maryland	should be and Mental marked o	ToB	William Edgar		ingtor			Mario		erson		
Na	Tra Tra		19a. Informant's Name/Relationship (Veronica Hill		ter					City or Town, State,		
ore,	iges 1 and of Healt of other	Ì	20a. Method of Disposition 1 Number 2 Cremation 3		20b. Pl	lace of Dispos emetery, cren	sition (Name of natory or other place	ce)	Date 2	Oc. Location - City o		
Baltimore,	t. Partmer rtmer rtent njury		*4 □Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer	1)	Mt.			ery 2-9		ansdrow		
g	Depa Depa Impo any i		Lloyd M. Est			E 3	step Bro 300 Euta	others . aw Place	Funeral e,Baltin	Ser,P.A nore,Md.	21217	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cau	th line.	. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death	
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a	NAL as a consequ		URE				4 DAYS	
	Examiner		Sequentially list conditions, if any leading to immediate b. METASTATIC COLORECTAL CANCER Due to (or as a consequence of):									
	rted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	ience of):						
o,	be executed siclen and burial-transit		that initiated events resulting in death) Last	Due to (or	as a consequ	uence of):			· · · · · · · · · · · · · · · · · · ·			
09/89	9 × 9	edicai		d								
O. Box	at the death certificat by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ∏Fetal nt at time of de	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	əlivəry Day Year	
<u> </u>	gned gned se de	by Pł	Part II. Other significant conditions of	ontributing to dea	th but not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba	*/-	to the cause of death?	
Records,	> 40 0	Completed							24a. Was an		autopsy findings available	
Re	ysicien: The law is certificate has b director, page 2 sl	omo							autopsy perform	prior to	completion of cause of	
Vita	Physicien: this certifical	Be	25. Was case referred to medical examiner?	Hospital:			Oth	00	th (Check only one			
	를 두 교	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of (Month,		ER/Outpatien 28b. Time of Injury	28c. Injur Wor	y at	ome 5 Resident	ce 6 Other (Sp v injury occurred	ecify)	
Division of	Attending Firdeath. ector: After by the funer.	icatio	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	1	-		M 1 🗆	Yes 2□No	20f Location (Star	and Number of F	Rural Route Number,	
N	el or Attend s after death il Director: A id in by the f	Certification:	4 Homicide determined	building	, etc. (Specify	/)	eet, factory, office		City or Town,		nural noute Number,	
	To the Hospitel or A within 24 hours after To the Funeral Direction completely filled in by	Medicai (29a. Certifier (Check only one) 1 Certifying Pt	ysician: To the b niner: On the bas and manne	is of examinat	wledge, death tion and/or inv	occurred at the tire vestigation, in my o	ne, date and place pinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner a e and place, and du	as stated. se to the cause(s)	
	To the To the Comp	Me	29b. Signature and title of certifier	D ₄	МΛ		29c. Licens	e number 5 -000		d. Date signed (Mor		
	10	2	Jewdom N/c	completed cause	of death (Item	23a) (Type	Print)				2,2005	
2) (A. //:	TEODORA NICULESCU	THE JOH	NS HOPE	UNS HO	SPITAL, GO	O NURTH W	VOLFE STRE	ET, BALTIMO	RE, MD 21287	
	Sta Registi		31. Date filed (Month, Day, Year) FEB 0 8 2		gistrar's Signa		and s					
DH	MH 17 Rev 1/2	001	1 4 0 0 7	103		1			***************************************			

ORIGINAL

			1- State of M Ragistrar	laryland / Dep <i>Ce</i>	partment of H Partificate of L		ntal Hygie		3669
	Diversitati		Decedent's Name (First, Middle, Last)				. Date of Death	Day Year	3. Time of Death
	Physici /Medio		Robert Augustus Huntley,				ANGERY	31, 2005	0441 M
	Examin	er	4a. Facility Name (If not institution, give street and number	,	4b. City, Town, or	Location of Death		4c. County of Death	091 A- 11 (m
	Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday	/) If Under 1 Year	If Under 24 Hrs. 8	Date of Birth	9 Birthol	ace (State or Foreign
	Director		5.79-79-5358 1₩ 2□F	52 Yrs.	Months Days	Hours Min.	(Month, Day, Ye ep. 30,	1952 Washi	ngton, DC
	low iow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation			10	d. Inside City Limits
	e Man	ctor	DC	Washingto	on				1 Yes 2 No
	with th	Director	10e. Street and Number		10f. Zip Code			Citizen of What Count	•
	ns 234	Funeral	4077 Minnesota Ave N.E. 11. Marital Status 12. Was Deceden	t Ever in U.S. 13.	. Was Decedent of Hi			ited State:	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. le marked other then "natural", or Items 23e or 28e-f show eumatic event, the Madical Exaction in the Control of the control of	þ	Amed Forces 1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Dates]No	If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Specif n, Mexican, Puerto Ric Specify:	can, etc.)	Black, White, e	
Maryland 21215-0036	hin 72 ho e. en "natur Modical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give	edent's Usual Occupa e kind of work done o DO NOT use retired	turina most of workina	16b	. Kind of Business/Ind	ustry
2	filed within Hygiene. other then "	Con	12	Nurs	se			ursing	
and	d be fill) Be	17. Father's Name (First, Middle, Last) Robert A. Huntley, Sr			18. Mother's Name (F Gladys E.		den Sumame)	
ary	should and Men marke umatic	7	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ling Address (Street a			ty or Town, State, Zip (Code)
	and 2 salth a n 27 le		Barbara Scott/ Sister		5 Monroe s	st N.E. Wa	shington	n, DC 20015	3
Š	iter		20a. Method of Disposition † Burial 2 □ Cremation 3 □ Removal from State		ematory or other place			. Location - City or Tov	
<u>=</u>	t. Pa rtmen rtant: njury		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servic → See	Ft. Linco		-		entwood, MI Funeral Ho	
B	Deparenti Importanti any ir		Ruhen Monno			ensburg Roa			20722
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	ed the death. Do not en	nter the mode of dying	g, such as cardiac or r	espiratory arrest,		Approximate Interval Between
-	nysician		Immediate Cause (Final disease or condition resulting in death)	osclerotro	· CArdier	Ascular 1	Heart I	Disease	Onset and Death
E	/Medical Examiner		Due to (or a	s a consequence of):					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e a consequence of):					
	ecuter and I-transi	Examiner	that initiated events .	s a consequence of):					
68760,	ificate be executed physician and as the burial-transit		3	za consequence on.					
89	rtificate ng phy as the	Aedical	JE 551411 5						
P.O. Box	The law requires that the death certifite has been signed by the attending bage 2 should be detached for use as	Physiclan/M		2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of deliver Month	y Day Year
ري م	w requires that the de been signed by the should be detached	by Pr	Part II. Other significant conditions contributing to death	but not resulting in the (underlying cause give	en in Part I.	23e. Did tobacc	co use contribute to the	cause of death?
ord	equire						1 🗌 Yes	2 No 3 Proba	bly 4 Unknown
	The faw ate has b page 2 sh	Completed					24a. Was an autopsy performed 1 Yes 2	prior to com death?	sy findings available pletion of cause of
Vita V	Attending Phyeician: r death. ector: After this certific by the funeral director.	Be	25. Was case referred to medical examinar? Hospital:		ent 3 DOA Othe	26. Place of Death (C			
ō	y Phye er this eral di	n: To	27. Manner of Death 28a. Date of Inj	ury 28b. Time o	all DOV	4 🗀 I fall string i Tollille	5 Residence d. Describe how in	6 □Other (Specify)	
ion	ath. rath. rr: Afte	atlo	1 Natural 5 Pending (Month, Ø 2 Accident investigation	ay Year) Injury		(? Yes 2 □ No			
Division of	lal or Attending Physician: The is after death. I Director: Atter this certificate he din by the funeral director, page	Certification;	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Ir building, 6	njury - At home, farm, st stc. <i>(Specify)</i>	treet, factory, office	28f	. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the bess 2 Medicel Examiner: On the basis and manner s	of examination and/or in	th occurred at the tim nvestigation, in my op	e, date and place, and pinion, death occurred	due to the cause at the time, date a	e(s) and manner as sta and place, and due to t	ted. he cause(s)
	To t To t	W	29b. Signature and title of certifier		29c. License	_		Date signed (Month, D	
1	10		30. Name and address of person who completed cause of	Do	HOO	55927	rel	reary 2,	2005
C	(1		Salvador Sylveter, 30	of Hospita	1 Drive	Cheve	ly Mon	my Mond	
	Sta Registr			trar's Signature	book		1/	/	

			1 - For State Registrar	State of Maryla	nd / Depa	artment of Heartificate of De	lth and M	ental Hygi	_	03670
	Physic /Medi Examii	cal	Decedent's Name (First, Middle, Last BERNICE 4a. Facility Name (If not institution, give	I street and number)	HOUCK	4b. City, Town, or Loc	ation of Death	2. Date of Death Month FEBRUARY	Day Yea 04 2005	
	Funeral Director		NORTH ARUNDEL H 5. Social Security Number 213-26-4548 Usual Residence of Decedent	7. Age (In yrs	i. last birthday) 90 Yrs.			8. Date of Birth (Month, Day,) March 29		UNDEL CO. irthplace (State or Foreign Zountry) Virginia
	the Maryland 28a-f show notified at	ector	10a. State 10b. County Maryland n/a		ity, Town or Lo Balti			100	Cisimon of Miles of	10d. Inside City Limits 1 12 Yes 2 1 No
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other then "naturel", or Items 23e or 28a-f show other treumatic event, the Madical Experient results to notified at	by Funeral Director	1113 Battery Aven 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	U.E 12. Was Decedent Ever in the Armed Forces? 1	ľ	21230 Was Decedent of Hispar f Yes, specify Cuban, M			J. Citizen of What (U.S. 14. Race - An Black, Wh Specify: W.	A . nerican Indian, lite, etc.
Maryland 21215-0036	filed within 72 ho Hygiene. other then "natur ent, II.e M. oleel I	Completed by	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupation kind of work done during DO NOT use retired) Seamstress	3			s/industry
laryland	2 should be fill and Mental H is marked otherwarked otherwarked otherwarked otherwarked otherwarked otherwarked in the second of	To Be	17. Father's Name (First, Middle, Last) C. Hesankia 19a. Informant's Name/Relationship (Ty	*	19b. Mailir	18.	Julia		Unkow	
Baltimore, N	Pages 1 and 3 nent of Health int: If item 27 iry or other tr		Stephen B. Houck 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)		Place of Dispo	3 Battery A sition (Name of natory or other place) en Mem Park	Da	ate 20	c. Location - City o	
■ Balti	perr it. Pages Department of Important: If i any njury or once		21. Signature of Fune all Service Lice 1. 23a. P. M. Enter the disease, or complete	Lamer	\mathcal{L} $\frac{M}{3}$. Name and Address of cCully-Poly 204 Mountai	niak Fu n Road.	neral Ho Pasaden	me P.A. a, Maryla	and 21122 Approximate
	Pnysician /Medical Examiner		spock, or heart failure. List only of dediate Cause (Final die ass or condition resulting in death)	a. Demon	quence of):				,	Interval Between Onset and Death
8760,	death certificate be executed e attending physician and of or use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.	quence of):					2 - 15.
P.O. Box 68	t the death certiff by the attending ached for use as	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	33c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feto 4 ☐ Pregnant at time of o 9 ☐ Unknown	aldeath 3□ death 5□	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
ecords,	law requires tha as been signed I 2 should be det	by	Part II. Other significant conditions con	ntributing to death but not res	sulting in the ur	derlying cause given in	Part I.	1 ☐ Yes	2 ⋈ No 3 □ P	o the cause of death?
Vital Re	The ate ha	Be Completed	25. Was case referred to medical examiner?			26.	Place of Death	24a. Was an autopsy performed 1 Yes 2 Check onlone	d? prior to death?	utopsy findings available completion of cause of
of	ing Phys After this uneral di	은	1 Yes 2 No P	lospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury at Work? M 1 Yes	28	e 5 Residence	e 6 ⊡Other <i>(Spe</i> inju ry occurred	ecify)
Division	Direction of	l Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of Injury · At h building, etc. (Special	fy) 			City or Town, S	State)	ural Route Number,
	To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	Medical	(Check only one) 29b. Signature and title of certifier	sicien: To the best of my knoner: On the basis of examination and manner stated.	ation and/or inv	estigation, in my opinion 29c. License num	n, death occurred	d at the time, date	Date signed (Mon	th, Day, Year)
	13		30. Name and address of person who co	impleted cause of death (Item	m 23a) (Type, I	Printack,		in olen	Burno)s U ø 6 4
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa		ule)		,	, ,	/ .

DHMH 17 Rev 1/2001

ORIGINAL

			Please I	ype or Prin								
			For State	State of Ma			te of Dea			od. No	4000	03671
			Registrar 1. Decedent's Name (First, Middle, Last)			Crimea	ic or bea		2. Date of Dea		•	3. Time of Death
Ė,	Physici			low1	и	nsel		F	Month Tebruar	y 4	. 2005	3:25 p M
	/Medic Examin		John B 4a. Facility Name (If not institution, give s	Sarl	110		, Town, or Locati				County of Deat	
	LAGITITI	ÇI ≊a	1125 South Carey S	treet		Ва	altimore				n/a	
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birthe	Months		nder 24 Hrs.	8. Date of Birth (Month, Day 09-11-	n /, Year)	9. Birti	nplece (State or Foreign untry)
L,	Director		214-24-6775	M 2UF	76 Yr	S.			09-11-	-192	8 Mai	ryland
	and wo		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					-	10d. Inside City Limits
	Many -f sh	to	Maryland n/a		Baltimo	re						1 Yes 2 □ No
	r 28e	Irec	10e. Street and Number				ip Code			10g. Cit	izen of What Co	untry?
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28e-f show that the Mcdical Examinar must be notified at	Completed by Funeral Director	1125 South Care	y Street			21223					
	lems er dea	nei	TI, Walta Gara	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X N	ver in U.S.	13. Was Dec II Yes, sp	edent of Hispanic ecify Cuban, Mex	Origin? (Spec kican, Puerto R	cify Yes or No- lican, etc.)		14. Race - Ame Black, White	
36	s afte	y Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X N If Yes, Give Year or Dates:	0	1 🗆 Yes	2 No Spe	city:			Specify:	White
8	tural	edt	15. Decedent's Educ	cation	16a. C	ecedent's Us	ual Occupation			16b. K	ind of Business/	Industry
212	hin 72	ple	(Specify only highest grade	completed) College (1-4or 5-	- 1	ife. DO NOT	rork done during use retired)	most ar warkin	9		hns Hop	
21	ad with	Com	3 years			inerat	or Opera				iversit	y
nd	be file d oth	Be	17. Father's Name (First, Middle, Last)	ш	ansel			fother's Name farv	(First, Middle,	Maiden		known)
<u>\S</u>	d Men narke	ဥ	Leonard 19a. Informant's Name/Relationship (Ty,			Asilina Addro	ss (Street and Nu	,	Route Numbe	r City		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28e-f show any injury or other traumatic event, the Modral Examiner must be notified at ODGs.		Edward Singer, Jr.		112	5 S. C	arey St	reet Ba	1timore	e, M	D 2122	3
	Heal Heal tem 2		20a. Method of Disposition		20b. Place of D	Disposition (N	ame of	Da	ate	20c. L	ocation - City or	Town, State
ē	Pages ent of nt: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ R * 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Bayvie	-		2-8-2	005	Ba1	timore,	Maryland
altimore,	mit. I partm porta porta r inju	- 1	21. Signature of Funeral Service Licens	ıθ	1 2,		and Address of F Ty-Polyr	acility Fu	neral H	Jome	P.A.	
m	Pe E E G		I I	Wayne Ost	erling	130 E	. Fort P	Ave. Ba	ltimore	≥, M	บ 2123	0
· ·			23a. Pand. Enter the disease, or complished, wheat is ilure. List only or	cations that caused	the death. Do no e.		- 2			rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	CORON	aru	Ante	ry Du	sea	He			Oliser and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):)					
	LXG.	20	Sequentially list conditions,	Due to the	consequence of	ms cc	ОИ					
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			,						
<u>,</u>	e be executed sician and e burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a	a consequence of):						
760,	sicia ysicia e buri	70	C.	d						.,		
Вох 68	Physician: The law requires that the death certificate it his certificate has been signed by the attending physical director, page 2 should be detached for use as the	Physician/Medio	IF FEMALE:								-	
Š	th cer tendir or use	an/N	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth		3 □Ectopic					23d. Date of del Month	ivery Day Year
	e dea the at ned fo	sici	1 ☐ Yes 2 Ø No 9 ☐ Unknown	4 □ Pregnant at 9 □ Unknown	time of death	5 Other (specify)					
P.O.	res that the designed by the a		Part II. Other significant conditions con	ntributing to death bu	it not resulting in	the underlying	cause given in F	Part I.	23e. Did to	obacco	use contribute to	the cause of death?
Records,	signe d be	d by	Emphyeome	7_					1021	res 2	□No 3□Pr	obably 4 Unknown
Sor	w require been sign	Completed	Donistina	Wale. 1	as Di	100	11		24a. Was	an	24b. Were at	itopsy findings available
Re	he la e has age 2	dwo	HID Slike	la saria						rmed?	death?	completion of cause of 2⊡ No
ta	an: T trificat tor, pa	Be C	25. Was case referred to medical	Coma			26. F	Place of Death			,	20.10
of Vital	ysici lis cer direc	To B	examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 🗌 Inpatie	nt 2 ER/Outp	patient 3	OOA Other: 4[Nursing Hom	ne 5 Aesid	dence	6 ☐Other (Spe	cify)
0 0	ding Physician: The lav n. After this certificate has funeral director, page 2		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Yea <i>r)</i> 28b. Ti	ury	28c. Injury at Work?		8d. Describe h	now inju	ry occurred	
Sio	Attending rt death. ector: After by the fune	catio	2 Accident investigation 3 Suicide 6 Could not be			M	1 🗆 Yes		10f Landian (f	74	ad Alverbas as O	und Doude Alive has
Division	5 # E c	Certification:	4 Homicide determined	28e. Place of Inju building, etc	iry - At home, fari c. (Specify)	n, street, lact	ory, office		City or Tox			iral Route Number,
ш	To the Hospital or Attenn within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Phy	sician: To the best of	of my knowledge.	death occurr	ed at the time, da	te and place. a	and due to the	cause(s	and manner as	s stated.
	e Hos 24 h e Fun etely	ledical		ner: On the basis of and manner sta	examination and							
	To th To th compl	Me	29b. Signature and title of certifier		11.21		29c. License num				ate signed (Mont	
•	_		Jourgara				D2160	+9		FR	bruary	7, 2005
The state of	0		30. Name and address of person who co		eath (Item 23a) (T	Type, Print)	4-	R. DL.	MANA	L	10212	7, 2005
-	4		JAMBANDAM BARK 31. Date liled (Month, Day, Year)		+55 WIL	Kens	/W .	pacti	MAR		122-12	
	St Regist	ate rar	FEB 0 8 2005	Clares A	a's Signatur							

				1- For State of Maryland / Department of He Registrar Certificate of D		ental Hygiei	71115	03672
_		Physici		1. Decedent's Name (First, Middle, Last) FOR / HO / O C		2. Date of Death Month	Day Year	3. Time of Death
		/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b. Gity, Town, or	Location of Death		4c. County of Death	12.70
		Funeral Director	1	5. Social Security Number 6. Sex 7. Age (In yls. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye,	9. Birth	iplace (State or Foreign intry)
		ryland how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
		h the Ma r 28e-f s	Director	10e. Street and Number 10f. Zip Code		10g.	Citizen of What Cou	1 Yes 2 □ No intry?
		death with the Maryland ms 23a or 28e-f show finust be notified at	Funeral D	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of His If Yes, specify Cuban	18 spanic Origin? (Spec	cify Yes or No-	14. Race · Ameri	ican Indian.
		ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other then "netural; or items 23a or 28e-f show if item 27 is marked other then" netural; or items 20a or 20e-f show or other treumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Specify Cuban 3 Widowed 4 Divorced Year or Dates:	n, Mexican, Puerto R Specify:	Rican, etc.)	Specify: Black, White	, etc.
	Maryland 21215-0036	hin 72 ho s. sn "netur Mcdical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary(Secondary (0-12) College (1-4or 5+)	turing most of working	g 16b.	Kind of Business/Ir	ndustry
	ld 21	filed with Hygiene other the	Be Com	Custodio	18. Mother's Name	(First, Middle, Maid	I Nas k	tuspital
	ıryları	should be nd Menta marked	ToB	2012 ROSe 19a. Informant's Name/Relationship (Type, Print). 19b. Mailing Address (Street ar	Hijda and Number of Rural	HOL Route Number City	lowar State	p Code)
	e, Ma	permit. Pages 1 and 2.9 Department of Health ar importent: if item 27 is eny injury or other treu once.		Hilda Holloway (Mother) 1923 Sway 20a. Method of Disposition (Name of	nseaz	oad;	Balto A Location - City or T	10 21239
	Baltimore,	t. Pages rtment of rtent: If it		Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify)	"teny 2/8	Ba	10.M	D
	Bal	Depar Impo eny ir		21. Signature of Funeral Service Licensee	re Ro	eve Fu	HOMD ?	1212
		Pnysician		23a. Part1. Effice the disease, or complications that caused the death. Do not enter the mode of dring, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
		/Medical Examiner		Due to (or as a consequence of):	7 3 711010	7712		years
	V	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events cause).				-
Z	9	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
919	9 X	certific Iding p	/Medi	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliving	
arl		0 0 0	Physiclan/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐			Month	Day Year
Th	ds, P	es pe	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	n in Part I.		use contribute to t	he cause of death?
5	Record	e law requit has been s je 2 should	ompleted			24a. Was an autopsy	24b. Were auto	ppsy findings available impletion of cause of
HOAM		i icien: Thi certificate rector, pag	Be Col		26. Place of Death (performed? 1 Yes 2	death?	2 12 No
2	o	Phys this ral dii	on: To	1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Cther. 27. Manner of Death	at 28	e 5 Residence		n Hospice
35	Division	or Attendi after death, Director: A in by the fu	Certification:		'es 2 □ No 28	8f. Location (Street and City or Town, Sta	and Number or Rure	al Route Number,
12/1		To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune		29a. Certifier 12 Certifying Physician: To the best of my knowledge death occurred at the time	e, date and place, an	nd due to the cause	c) and manner as e	tated.
-	:	To the Hospitel within 24 hours a To the Funerei C completely filled	Medical	one) and manner stated. 29b. Signature and title of certifier 29c. License r	number	29d. D	ate signed (Month,	Day, Year)
				30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	4170 St Bal	Fe	bruary 2	, 2005
		J Sta	to-	E. To MD Richey Hospice 838 Eutaw 31. Date filed (Month, Day, Year) 32. Projector's Signature	St Bal	timore	MD 21	201
		Registr		31. Date filed (Month, Day, Year) FEB 0 8 2005 32. Projector's Signature.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 7, **Physician** Bertha E. Hediger February 2005 6:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7812 Maryknoll Avenue Bethesda Montgomery 8. Date of Birth (Month, Day, Yea A119, 23, 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Germany Days Hours 1 □ M 2 🖾 F 98 144-24-3335 Yrs Director Ĩ́906 Usual Residence of Decedent 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits itam 27 is markad othar than "natural", or items 23a or 28a-1 show othar traumatic evant. The Modical Examinar must be notified at Be Completed by Funeral Director 1 ☐ Yes 2 ▼ No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7812 Maryknoll Avenue 20817 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
not if item 27 is marked other than "natural", or lies
nry or other traumatic event, the Marical Fatricina. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify. White Specify 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jelsche Bunger ၀ Baulina Breuser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilde H. Kochanek/Daughter 7812 Maryknoll Avenue, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State February 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or * 4 ☐ Donation 5 ☐ Other (Specify) Scotch Plains, NJ Hillside Cemeterv 2005 21. Signature of Funeral Servi Licensee 22. Name and Address of Facility Bethesda-Chevy Robert A. Pumphrey Funeral Home/ M00198 7557 Wisconsin Ave., Bethesda, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Unidentifying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner the burial-transit or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Anemia 24a. Was an autopsy performed? Goiter 2□ No 1 ☐ Yes 2X No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 🔀 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident in by the 6 Could not be determined 3 🗍 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled To the Hospital within 24 hours a To tha Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical 29a. Certifier Medi and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7 MD 05 MD 0059794 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Lele Luu, M.D.

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

32 Registrar's Signature

1201 Seven Locks Road, Rockville, Maryland

_			State of Maryland / Department of Health and M 1 - State Registrar Certificate of Death		ene 2005	03674
	Physic /Medi		nutri ii ilougii	2. Date of Death Month February	Day Year OZ Zoo5	3. Time of Death 1 2 '.50 A M
1	Exami	ner	Union memorial Hospital Baltimore		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 Months Days Hours Min. 1 M 2 F 7. Age (In yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. Months Days Hours Min. Usual Residence of Decedent	8. Date of Birth (Month, Day, Y	9. Birthp	lace (State or Foreign try)
	the Marylan r 28a-f show	ctor	10a. State 10b. County 10c. City, Town or Location Baltimore		1	od. Inside City Limits 11 Yes 2 □ No
		Funeral Director	10e. Street and Number 10f. Zip Code 701 N. Arlington Ave. Apt. 507 2/2/7	100	Citizen of What Coun	try?
36	or fte	by Fune		cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, of Specify: 12 / A	
215-0036		Completed		ng 16	b. Kind of Business/Inc	ustry
nd 2121	nit. Pages 1 and 2 should be filed withir artment of Health and Mental Hygiene. ortant: If itsm 27 is marked other than injury or other traumatic event, the M. 8.	Be	17. Father's Name (First, Middle, Last)	(First, Middle, Ma	Ome iden Sumame)	
Maryland	12 should h and Men 7 Is marke raumatic	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural	'A	. 1:	
_	permit. Pages 1 and Department of Health Important: If itam 27 any injury or other tr once.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		Bûlto, MD c. Location - City or To	
Baltimore,	permit. Pag Department Important: I any injury c		21. Signature of Friedral Service Licenses		Ulimore, r	nd alaa9
	Priysician		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate cause (Final disease or condition			Approximate Interval Between Onset and Death
	/Medical Examiner	L	Due to (or as a consequence of): Sequentially list conditions b. CI Bleeb			
	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underhing Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
68760,	ificate be ex g physician as the buria					
O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of deliver Month	y Day Year
ords, P.	w requires that been signed I should be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobace	co use contribute to the	cause of death?
Il Records,		Completed		24a. Was an autopsy performed 1 Yes 2 🐯	? prior to com death?	sy findings available pletion of cause of
of Vital	Physician: Th this certificate ral director, pag	o Be	examiner? 26. Place of Death (
Division of	il or Attanding Phys after death. Diractor: After this d in by the funeral di	atlon: To		e 5 ∐ Residence 3d. Describe how in	e 6 □Other (Specify) njury occurred	
Divis	To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:		City or Town, Si		
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical		nd due to the cause d at the time, date	e(s) and manner as stal and place, and due to t	ed. ne cause(s)
	viti To con		MC Emmi MD ATZ438946-E		Date signed (Month, Div $Z/OZ/Z$	
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ali Esmulli Union Memorial Hospital, 201 East University Pic			
חשו	Sta Registr MH 17 Rev 1/20	ar	FFB 0 8 2005 Person 16 April 1			
214	1107 1/20		ORIGINAL			

State of Maryland / Department of Health and Mental Hygienes Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JOSEPH FREDERICK KOHLER 7:25A 2005 /Medical rebruary 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ST. JOSEPH MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/3/1924 **Funeral** Birthplace (State or Foreign Country) Hours 1 € M 2 □ F Director 219-18-8422 Yrs 80 MARYLAND Usual Residence of Deceden 10a. State 10b Count 28a-f ahow 10c. City, Town or Location 10d. Inside City Limits traumatic evant, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No MD BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a or 1550 DELLSWAY ROAD 21286 death Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WW II 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No ģ 3 □XVidowed 4 □ Divorced Specify: WHITE natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. MANUFACTURING-Elementary/Secondary (0-12) College (1-4or 5+) AUTOMOTIVE PARTS YEARS MANAGER marked othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental F is marked of JOSEPH KOHLER HELEN ROSTKOWSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If itam 27 is any injury or other trains000. LANCE KOHLER/SON 8430 PLEASANT PLAINS ROAD TOWSON, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) METRO CREMATORY, INC. 2/5/2005 CATONSVILLE, MD 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD and. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The faw requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, been signe should be d DISCASE1 Yes 2 No Completed 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 1 Yes 2 No case referred to medical iner? or Attanding Physician; Certification: To Be 26. Place of Death (Check only one, Hospital 1 Yes 2 No 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3∏ DOA 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending investigation death. s after death. 2 Accident the 6 Could not be 3 ☐ Suicide filled in by Location (Street and Number or Rural Route Number 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 5+1 30. Name and address of person who commeted cause of death (Item 23a) (Type, Print) 7 YEDICAL ARTS -7505 MO - O'DEA 31. Date filed (Month, Day, Year) 32. Regio rar's Signature 501 - TOWSON, HD 21209 State Registrar

		1	For State Registrar	State of Maryl	and / Depa			Mental Hygi	ene g. No. 200	5 03676			
	Physici	an	1. Decedent's Name (First, Middle, Last)	Ison				2. Date of Death Month January	Day Yea	3. Time of Death			
4	/Medio		Walter Irvin 4a. Facility Name (If not institution, give s		ture		r Location of Death		4c. County of D	eath			
1		•	1300 S. Ellwood 5. Social Security Number 6. Sex		omewood yrs. last birthday)		Utimore If Under 24 Hrs.	9 Date of Birth	N/				
	Funeral Director		216-30-1211	M 2□F 71		Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan. 22,	1934	Birthplace (State or Foreign Country) Maryland			
	yland		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	ocation				10d. Inside City Limits			
	he Mar	ector	Maryland N/A 10e. Street and Number			Baltin 10f. Zip Code	nore	10	g. Citizen of What	1X Yes 2 □ No			
	3a or	i Dir	3043 Mayfield Aven	110		Tot. Zip Code	21213		u. s				
	tems 2	uner	11. Marital Status	Was Decedent Ever i Armed Forces?	in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		merican Indian,			
9800	72 hours after death with the Maryland natural', or Herns 23a or 28a-f ehow deat Exand at must be codified at	Completed by Funeral Director	1 Never Married 2 X Married 3 Widowed 4 Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:			vhite			
and 21215-0036	in 72 h n "natu ezileu	piete	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most of work d)	rina	6b. Kind of Busine Social S	•			
212	ed with yglene her tha		9th Grade	College (1-40) 3+)		Shop Steu			<u>Administ</u>				
land	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturat", or Items 23a or 28a-f ehow any injury or other traumatic event, the Medical Erann set must be invittled at ance.	To Be	17. Father's Name (First, Middle, Last) Ernest Ison					l Jacobs	alden Surname)				
Õ	d 2 sho th and I th small trauma		19a. Informant's Name/Relationship (Type Darlene Ison (daug				and Number or Rule Garth, A						
ore,	as 1 an of Heal item 2 r other		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □ Ri	20		osition (Name of matory or other pla			0c. Location - City				
Baltimore	t. Page ntment rtant; ii		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	<u>B</u>		Crematory				, Maryland			
Bal	Depermine Depermine suny in concession		Buin G. L	Velly			ess of Facility Sch			and 21213			
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										
3760,	ate be executed hysician and he burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor		gross,							
P.O.	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pro 1 □ Live birth 2 □ i 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnanc	у		23d. Date of Month	delivery Day Year			
	uires that signed b		Part II. Other significant conditions con	tributing to death but not		nderlying cause giv		23e. Did toba		e to the cause of death? Probably 4 Minknown			
Records,	sician; The law req s certificate has beer lirector, page 2 shou	Completed by	acate Re	end of a	nainy milh fi	in .		24a. Was an autopsy perform	prior				
Vital	Physician: this certificatal director, I	Be	25. Was case referred to medical examiner?	ospital:		Ott		th (Check only one					
of	Phy this ral d	n: To	27. Manner of Death	1 Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatie 28b. Time of Injury	nt 3LI DUA	4 Nursing H	ome 5 Residen 28d. Describe hov		pecify)			
Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp.	At home, farm, st	M 1	Yes 2 □ No	28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,			
Ω	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	sai Ce		ician: To the best of my									
	thin 24 the Fi	Medic	one) 2 Medical Examir one)	and manner stated.	amanon and/or in	29c Licens	e number	29	Date signed (Mo	onth Day Year			
	Z × Z	_	1 /hts	Zih m	6	≪ X	11150	0	1/27/2	005			
,	2		30. Name and address of person who co	Tonnes,	MO 44	Print) EC	Lwoodf	WE BAC	TO, M9	21224			
	Sta Registi		31. Date filed (Month, Day, Year) FEB 0 8 2005	Registrar's S	signature	de							

			For State	State of Maryland / D	epartment of He		ental Hygier	4000	03678
			Registrar 1. Decedent's Name (First, Middle, Lateral Control of the Control of t				2. Date of Death		3. Time of Death
	Physicia		Willian	T. Johns	5 12			Day Year	2252 PM
	/Medic		4a. Facility Name (If not institution, give		4b. City, Town, or L	ocation of Death		4c. County of Deat	
	Examin	er		rock Trauma Center	0			,	
	Freezest		5. Social Security Number 6. S	ex/ 7. Age (In vrs. last birth	nday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birtl	nplace (State or Foreign
	Funeral Director		213.38.9832	May off the	rs. Months Days	Hours Min.	(Month, Day, Yea	141 M	LYLAND
			Usual Residence of Decedent				105-11		Ty Critical Control of the Control o
	yland		10a. State 10b. County	10c. City, Town	or ocation				10d. Inside City Limits
	Mar.	ţō	$\mathcal{M}_{\mathcal{D}}$		DAUTIMOR	E			1 ☐Yes 2 ☐ No
	r 288	rec	10e. Street and Number	^	10f. Zip Code		10g. (Citizen of What Co	untry?
	13a o	<u>_</u>	1917 SWANSE	A KOAD		21239		U.S.	A.
	deeth with the Maryland ime 23a or 28a-f ehow r must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armyd Forces?	13. Was Decedent of His If Yes, specify Cyban	panic Origin? (Spe	cify Yes or No-	14. Race - Ame Black, White	
9	after or Ite	Ī	1 ☐ Never Married 2 ☐ Married	1 Yes 2 □ No	1 ☐ Yes 2 V No	Specify:	Tioari, etc.)	//	ACK
21215-0036	hours after tural', or Ite	l by	3 Widowed 4 □ Divorced	Year or Dates:	10 165 202110	ореспу.		Specily. 150	7101
5	72 h	etec	15. Decedent's Ed (Specify only highest gra	ide completed)	Decedent's Usual Occupat (Give kind of work done du	ion uring most of worki	16b.	Kind of Business/	ndustry
7	within ene. than "	npi	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	cos	20		City
	e filed within al Hygiene. I other than '	Completed		<i>L</i>	SUPERVI.			TIMORE	City
p	tal H d oth	Be	17. Father's Name (First, Middle, Last)		Q I	18. Mother's Name	(First, Middle, Maid	en Sumame)	1.1
yla	Men Men arke	မ	WICLIAM 1.	JOHNSON, SI).	LOUR	se J	OHNSU	N
Maryland	s 1 and 2 should be filed within 72 hours after deeth with the Marylan f Health and Mental Hygiene. itam 27 ie marked other than "natural", or Iteme 23a or 28a-f ehow other traumatic event. If a Modical Expril at mast ke notified at		19a. Informant's Name/Relationship (Mailing Address (Street ar	. 0	Λ	4.4	ip Code)
-	and lealth m 27		WILLIAM T. JOHNSI		2 SWANSE		BAUTIMO		CAND 2/239
ore	iges 1 it of H it it a		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	cometon	Disposition (Name of c, crematory or other place,)		Location - City or	14
Ĕ	Pages ment of ant: If it ury or o		* 4 □ Donation 5 □ Other (Specif		on torest	12.9	1.08 CWI	NGS MILLS	MARYLAND NEEDE HOME
Baltimore	permit. Pages Department of I Important: If it any Injury or o		21. Signature of Funeral Service Licer	nse	22. Name and Address	of Facility VAC	EHN C G	REENE FU	NEXIC HOME
m	207 2 2	11.5	Caughi	Xreed	4905 YUK	K KOAD	BOUTIM	ORF, MAI	LYLAND 2DIZ
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do not one cause on each line.	ot enter the mode of dying,	, such as cardiac o	r respiratory arrest,	'	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	5" NC'C					Onset and Death
	/Medical	1	resulting in death)	Due to (or as a consequence o	f):				INCOS
н	Examiner			, Streptococc		Incak			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence o		4			
V	cuted od ransii	Examiner	Cause (Disease or injury that initiated events	· Bilateral Le	a Cellul:	2:1			Incek
o,	exection and arriginal-tr		resulting in death) Last	Due to (or as a consequence e	_ ^				2
8760	cate be executed physician and the burial-transit	dicai	(a Bilateral Le	& VecpVer	aus Thro	2:206m		INCEK
9	ig ph as th	ed			J '				
Вох	that the death certificed by the attending podetached for use as	Physician/Me	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3⊟Ectopic pregnancy			23d. Date of deli	
	deatle e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of death	5 Other (specify)			Month	Day Year
P.O.	t the	hys	9 🗆 Unknown	9 Unknown					
	res that igned to be det	by P	Part II. Other significant conditions of	contributing to death but not resulting in	the underlying cause giver	n in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ds	n sig	d b					1 🗆 Yes	2 1 No 3 □ Pr	obably 4 Unknown
Vital Records,	law requires that the as been signed by th 2 should be detache	Completed					24a. Was an	24b. Were au	topsy findings available
Re	Ф <u>г</u> Ф	Ę.					autopsy performed	? death?	completion of cause of
a	ician: Th certificate rector, pag	e Cc	25. Was case referred to medical			26. Place of Death	1 Yes 2 1	No 1 ☐ Yes	2 No
\equiv		o Be	examiner?	Hospital: 1 Inpatient 2 ☐ ER/Out	Other	~	ne 5 Residence	6 □Other (Sner	rifu)
ō	Phys r this ral di	-	27. Manner of Death	28a. Date of Injury 28b. Ti			28d. Describe how in		,ny)
O	Attending r death. actor: Afte by the fune	tion	1 ☑Natural 5 ☐ Pending	(Month, Day Year) In		es 2 No			
S	death. ctor: Al	fica	3 Suicide 6 Could not b	B One Blees of Injury. At home for	m, street, factory, office	2	28f. Location (Street	and Number or Ru	ral Route Number,
Division of	after after Dira	Certification:	4 Homicide determined	building, etc. (Specify)	,		City or Town, St	ate)	
_	To the Hospital or Attending Phwithin 24 hours after death. To tha Funeral Diractor: After th completely filled in by the funeral	C	29a. Certifier 1 Certifying Pl	nysicien: To the best of my knowledge,	death occurred at the time	e, date and place a	and due to the cause	(s) and manner as	stated.
	Hou 24 hi Fun stely	edicai	(Check only 2 Medicel Examone)	niner: On the basis of examination and and manner stated.	Vor investigation, in my opi	nion, death occurre	ed at the time, date a	and place, and due	to the cause(s)
	To the within 2 To tha complet	Me	29b. Signature and title of certifier		29c. License	number	29d. I	Date signed (Monti	n, Day, Year)
	⊢ 3 - 3				144	1710		1/3:105	
			Whan C	completed cause of death (Item 23a) (1 3110	ر
	11		William (Cl.	1 M.O. A. 1.1 (C.	secost.	Balt ma	re m	21201	
	Sta	10	31. Date filed (Month Park, Year)	2005 32. Registrar's Signature	Agasti)		- 1. 9	3 ,0-01	
	Sta Registr		LER A O	1003					

Physici		1 - For Amend Item 8 Registrar		545,077	Cer	tificate	of Dea				05 0367			
100-11	an	1. Decedent's Name (First, Middle, Last) 2. Date of Month									Year			
/Medic		Ethel K 4a. Fecility Name (If not institution, give	nox			4b. City, Tov	vn or Locatio	on of Death	2	005 8:25 A A				
Examin	ıer	Forestville Healt		lition	.	15. Oxy, 10.		tville						
Funeral		Social Security Number 6. Se	ex 7. Age	(In yrs. last b		If Under 1 Y Months D	ear If Und	der 24 Hrs. 8	. Date of Birth					
Director		1/4-22-1493	□M 2⊠F	84	Yrs.	Months	ays Hour	o viiii.	Date of Birth (Month, Day)4/08/1	920				
\$120°		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loc	cation		-			10d. Inside City Limits			
1 sho	ō	MD Prince Ge	eorge's	,			ge Par	k						
r 28a	Director	10e. Street and Number			-	10f. Zip Co	de		10	g. Citizen of V	Vhat Country?			
23a o	aiD	6100 West Chester	Park Dr.				207	40			U.S.A			
rai', or items 23a or 28a-f show Exemples in ust be multiled at	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent Yes, specify	of Hispanic Cuban, Mexi	Origin? (Specifican, Puerto Ric	fy Yes or No- can, etc.)					
, or l	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 📉 No If Yes, Give Year or Dates:		1	☐ Yes 2🏋	No Spec	cify:		Specify	Black			
"natural", dical Exc	edt	15. Decedent's Edu		168	a. Deced	ent's Usual O	ccupation		1	6b. Kind of Bu	siness/Industry			
- 49	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+		(Give I	kind of work d OO NOT use re	one during n etired)	nost of working						
	E O	12th Seamtress								Pvt				
tal Hygie d other event, il	Be (17. Father's Name (First, Middle, Last)					18. Mc	other's Name (F	First, Middle, M					
nd Mental marked o metic eve	은	Angelo	Atkins					he1			nillips			
h and 7 Is m traum		19a. Informant's Name/Relationship (T) Silas K. Malik/ S	•					mber or Rural F 1 Seabr		City or Town, . MD 207	State, Zip Code)			
of Health and Ment fitem 27 is marked r other traumetic (20a. Method of Disposition				sition (Name o		Date			City or Town, State			
t: Kil		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)						2///05						
Depertment of H Importent: If ite any injury or ot once.		21. Signature of Fund al Service Licens		Kivero		Cremat Name and A		2/4/05		iverdal s Funer	al Home			
Impo any ir			Rx					Rd. I						
		23a. Part Fnter the alsease, or comp shock, or near failure. List only o	plications that caused to	he death. Do	not ente	r the mode of	dying, such	as cardiac or re	espiratory arre	st,	Approximate Interval Between			
ysician		Immediate Cause (Final disease or condition		id Stag	ze Li	iver Ci	irrhos	is			Onset and Death			
Medical		resulting in death)	aDue to (or as a											
aminer		Sequentially list conditions,	bI	lepatit	is (C Posit	ive A	ntibody	7					
sit	iner	if any, leading to immediate Due to (or as a consequence of).												
and I-tran	хап	that initiated events c. The seulting in death) Last Due to (or as a consequence of):												
physicien and the burial-transit	a E													
physis the	edicai		0.											
attending pl	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o			eu des distan	UL III			23d. Date	e of delivery			
the atte	icia	in the past 12 months? 1								Mon	Month Day Year			
ac b	hys	9 ☐ Unknown SE Officions Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
be be	by										bute to the cause of death?			
been s	ompieted						-		1 L Yes	2 🗆 No	3 Probably 4 X Unknown			
2 0	npie								24a. Was an autopsy	DI DI	Vere autopsy findings available rior to completion of cause of			
pag	S								perform 1 ☐ Yes 21		eath? □ Yes 2 No			
	Be	25. Was case referred to medical examiner?	Hospital:				Other	ace of Death (C	-					
certifi	2	1 Yes 2 No	1 ☐ Inpatien				4 🗸	Nursing Home 28d						
this al di	- a-	1 Natural 5 Pending (Month, Day Year) Injury Work?							8d. Describe how injury occurred					
After this uneral di	tion	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of thijury: At home, farm, street, factory, office 28f. Location (Str.								et and Numbe	r or Rural Route Number,			
leath. tor; After this the funeral di	ification	3 Suicide 6 Could not be	286. Place of injur	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)										
iter death. Nirector; After this n by the funeral di	Certification	3 Suicide 6 Could not be	286. Place of injur	(Specify)										
iter death. Nirector; After this n by the funeral di	lical Certification;	3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier (Check only) 2 Medicel Exami	building, etc. ysician: To the best of iner: On the basis of e	my knowledg	e, death	occurred at the	e time, date	and place, and death occurred	I due to the cau at the time, dat	se(s) and man	nner as stated. nd due to the cause(s)			
iter death. Nirector; After this n by the funeral di	Medical Certification:	3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier 1 XCertifying Phy	building, etc.	my knowledg	e, death nd/or inve	estigation, in r	ne time, date ny opinion, d cense numbe	death occurred	at the time, dat	e and place, a	nner as stated. nd due to the cause(s) (Month, Day, Year)			
After this uneral di		3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier (Check only one) 1 Certifying Phy 2 Medicel Exami	building, etc. ysician: To the best of iner: On the basis of e	my knowledg	e, death nd/or inve	estigation, in r	ny opinion, d	death occurred a	at the time, dat	e and place, a	nd due to the cause(s)			
within 24 nours after death. To the Funerel Director; After this completely filled in by the funeral di		3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier (Check only one) 1 Certifying Phy 2 Medicel Exami	vsician: To the best of iner: On the basis of and manner state	my knowledg ixamination ai ed.	nd/or inve	29c. Lic	ny opinion, d cense numbe	death occurred a	at the time, dat	e and place, a	nd due to the cause(s)			
iter death. Nirector; After this n by the funeral di		3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier (Check only one) 1 Certifying Phy 2 Medicel Exami	vsician: To the best of iner: On the basis of and manner state	my knowledg ixamination ai ed.	nd/or inve	29c. Lic	ny opinion, d cense numbe	death occurred	at the time, dat	Date signed	nd due to the cause(s)			

		•	For State Registrar		State	of Maryl	and / Dep <i>Ce</i>	artmen rtificat			and M		giene Reg. Ner	005	036	80	
	Physici	an	Decedent's Name	(First, Middle, La								Date of Death Month Day Year			Death		
	/Media	cal	FATMATTA			KABE	3A	4h Cihi	Taua as	Location of	f Dooth	2/04/2005 1:50 M					
4	Examin	er	4a. Facility Name (If r		e street and i	4b. City,		NHAM	n Death				George's				
	Funeral		5. Social Security Nur	mber 6.5			yrs. last birthday,	If Under	1 Year	If Under	24 Hrs. Min.	8. Date of Bird (Month, Da	th	9. Birth	place (State o	or Foreign	
	Director		219-67-04	42	□м 2 Х О F		69 Yrs.	Months	Days	Hours	MIII.	05/14/1		Sier	ra Leo	ica ne,	
	land ow			10b. County		10c.	City, Town or L	ocation							10d. Inside Ci	ity Limits	
	the Marylar 28a-f show	ctor	MD	Prince	George	e's		Lan	ham						¹ X Yes	2 🗆 No	
	th with 23a or	Funeral Director	10e. Street and Numb 7018 Dolp					10f. Zip		0706			10g. Citiz	ush of What Co	untry?		
	Itams Itams	uner	11. Marital Status		Armed	ecedent Ever in Forces?	n U.S. 13.	Was Deced If Yes, spec	lent of Hi	spanic Orig n, Mexican	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	- 1	 Race - Amer Black, White 			
36	al', or	þ	1 Never Married 3 Widowed 4		If Yes,	s 2. ▼ No Give r Dates:		1 🗆 Yes :	2□No	Specify:				Specify: B1	ack		
2-0	"natural",	sted	(Specifi	5. Decedent's E	ducation	cation 16a. Deced			il Occupa	ation Jurina most	of worki	na	16b. Kir	nd of Business/I	ndustry		
21215-0036	ne. han "	Completed	Elementary/Second		College (1-4or 5+)			re kind of work done during most of work DO NDT use retired) Home—maker						Priv	ate		
	filed with Hygiene. other ther		17. Father's Name (F	irst, Middle, Last)						r's Name	(First, Middle,	Maiden :				
lan'	should be filed withir of Mental Hygiene. marked other then mattc event, the Mental the	To Be	Sorie		Kabba	a				Kad	ijah			Cont	eh		
Maryland	2 shoul and Ma is marl raumati		19a. Informant's Nan	. ,			1	-					-	Town, State, Z	ip Code)		
	1 and 1 Health am 27		Mohammed 20a. Method of Dispo		7 Son	20	b. Place of Disp	Dolpl osition (Nan	ne of	1		ham, MD Date		U6 cation - City or 1	Fown, State	- 7	
mor	Pages nent of l int: If It, iry or o		1 🔯 Burial 2 🗆				cemetery, cre George 1	-		. !	2/7	/2005	1ahA	phi, MD			
Baltimore,	permit. Pages 1 an Department of Heal Important: If Itam 2 any injury or othar once.		21. Symmetry of Fun				2	2. Name an 7474 I	d Addres	s of Facilit	y J .	B. Jenk	ins	Funeral D 20785	neral Home		
	Physician	65	23a. Part . Soter the disease, er complications that caused the death. Do not enter the mode of dying, such as care shock, or heart failure. List only one cause on each line. Immediate Cause (Final									e or respiratory arrest, Approximate Interval Between Onset and Death					
	/Medical Examiner		disease or condition resulting in death)	(a Due	to (or as a con	sequence of):	2 10	VIVI	1.4		0000		٠.			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury														
7	e be executed /sician and e burial-transit	Examiner	Cause (Disease or in that initiated events resulting in death) La		c	to (or as a con:	saguance of):										
8760,	sician burial		,	l	4	10 (01 43 4 0011	304231100 017.										
9	ifficate g phys as the	edic			_ 0												
Вох	leath certifica attending ph	an/M	IF FEMALE: 23b. Was decedent p						3 □Ectopic pregnancy				23d. Date of de Month			fear	
.O. E	the at	Physician/Medical	in the past 12 m 1 Tyes 2 T 9 Tunknown		4□Pre 9□ Un	egnant at time (known	of death 5[Other (sp	ecify)	-				WOIL	Day 1	1 641	
۵.	res that the de signed by the a be detached t	by Ph	Part II. Other signific	ant conditions	contributing to	ting to death but not resulting in the underlying cause given in Part I.					23e. Did to	23e. Did tobacco use contribute to the cause of death?			eath?		
ord	w require been sig should b	ted I					-					1 🗆 \	/es 2	2No 3 □ Pro	bably 4 🗀	Jnknown	
Records,	The lar ate has page 2	Completed									_	24a. Was autop perfo 1 Yes		prior to condeath?	opsy findings a ompletion of ca 2 \(\text{\square}\) No	available ause of	
Vital	Physician: The L this certificate ha ral director, page:	Be	25. Was case reterre examiner?	o medical	Magaital				04		of Death	(Check only o	ne)				
of	this al di	To T	1 Yes N	0			2 ER/Outpatie			4 🗀 Nu	rsing Hor	ne 5 Resid		Other (Spec	ify)		
lon	Attending F r death. actor: After by the funera	atlon	Natural 2 Accident	5 Pending investigatio	1	te of Injury Ionth, Day Year	r) Injury	м	8c. Injury Work 1 🔲 Y	? /es 2 □ l							
Division	after death after death Diractor: A d in by the fu	Certification:	3 Suicide 4 Homicide	6 Could not be determined	1 28 9 , Pla	ace of Injury - A ilding, etc. (Sp	At home, farm, st ecify)	reet, factory	r, office		1	28f. Location (S City or Tow		Number or Rui	ral Route Num	ber,	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		☑ Certifying Pi	niner: On the)	
	To th withir To th comp	Me	29b. Signature and i	Le of centries	1111	TD	WAN	290	License		717		29d. Date	signed (Mohth	, Day, Year)		
	χ_j		1		////		17/17	Paris 1	UU	053	210		4		<u>`</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NICHOLAS AZINUE, 620 Green bett Rd, Swite State 31. Date filed (Month, Pay, Year) 32. Resistrar's Signature										EM-1	700	(lege P)	S MAZ	0740			
	Sta Registr		31. Date filed (Month	EB'0'8	2005	Alches.	y a later of	gosoli	P					4			

		1 - For State Registrar		Marylar	nd / Depa <i>Cei</i>	artmen rtificat	t of H e of L	ealth a Death		Re	ene 00	
Physicia /Medic	al.	1. Decedent's Name (First, Middle, L Dolores E. Kyri	acos						F	Date of Death Month	Tay y T 2	ear 9:55AM
Examin		4a. Facility Name (If not institution, grant Union Memorial	Hospital	oer) . Age (In yrs.	Inst highday)			Location of Ltimor	ce	Date of Righ	4c. County of	
Funeral Director			1 M 2 F	68	Yrs.	Months	Days	Hours	Min.	Date of Birth (Month, Day, ar. 22,	1936	Maryland
Maryland	tor	10a. State 10b. County Maryland N/A		10c. Cit	ty, Town or Lo Bal	cation timo:	re					10d. Inside City Limits 1122Yes 2 ☐ No
h with the 23a or 28e at be not	Funeral Director	10e. Street and Number 3018 E. Darby S	treet	•		10f. Zip		21211		10	g. Citizen of Wha	at Country? SA
urs a	۱۵	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	es? ☑ No		Was Dece If Yes, spe 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Specify , Puerto Rica	Yes or No- an, etc.)		American Indian, White, etc. White
within 72 ho lene. than "naturi he Wedical I	Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4	lor 5+)		dent's Usu kind of wo DO NOT u	rk done d se retired	ation furing most)	of working		6b. Kind of Busin	e Company
should be filed within the Mental Hygiene marked other the matte event, the Mental the M	To Be C	17. Father's Name (First, Middle, Las John Kilduff	t)					Ge	ertrud	e Ba	aiden Sumame) aldwin	
and 2 should alth and Men 27 is marke er traumatic		19a. Informant's Name/Relationship Terri Goodman	(Type, Print) Daugh		301	8 E.	Dart	y Str			city or Town, Sta ce, Mary	ate, Zip Code) 1and 21211
Pages 1 an hent of Heal nt: If item 2 iry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Special Control of C	□Removal from Si	ate +	Place of Dispo cemetery, crei coudon				Date 2/7/20	3	oc.Location - Cit	y or Town, State , Maryland
permit. Pages. Department of P Important: If ite any injury or of		21. Signalury of Funeral Service Lice		1				s of Facility enss-S s Roa		Funeral ltimore	Home,	Inc. 21211 and
Physician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	y one cause on ex	h line.	th. Po not ent	er the mod	e of dyin	g, such as	cardiac or re	spiratory arres	st,	Approximate Interval Between Onset and Death
Example of executed wishing the purial-transit and the purial-transi	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (o	r as a conseq r as a conseq r as a conseq	juence of):							11 days
death certific e attending p ed for use as f	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown		h 2∐Feta ntattime of c	Ideath 3	Ectopic p					23d. Date o Month	of delivery Day Year
es the	2	Part II. Dther significant conditions	contributing to dea	th but not res	sulting in the u	nderlying o	ause give	en in Part I.		23e. Did toba	-W	te to the cause of death? Probably 4 Unknown
The law ate has b page 2 s	Completed										prio dea	re autopsy findings available r to completion of cause of th? Yes 2 No
8 ≅ ₽	To Be	25. Was case referred to medical examiner? 1 Yes 2 10	Hospital:	mient 2	ER/Outpatier	nt 3 🗆 D0	Othe Othe	200		heck only one, 5 ☐ Residen	ce 6 Other	(Specify)
Attending Ph r death. • ctor: Atter th by the funeral		27. Manner of Death Natural 5 Pending 2 Accident Investigati	on	Injury <i>Day</i> Year)	28b. Time of Injury	М	28c. Injury Work 1 🔲 `	rat (? Yes 2 □ N		Describe how	injury occurred	
Hospital or Attence 4 hours after death Funeral Director: tely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not determine	286. Place 0	f Injury - At h g, etc. <i>(Specil</i>	ome, farm, str	eet, factor	y, office		28f.	Location (Stre City or Town,		or Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier Certifying F (Check only one)	Physician: To the baseminer: On the basemand manner	is of examina	owledge, death ation and/or in	h occurred vestigation	at the tim , in my of	ne, date and pinion, deat	d place, and th occurred a	due to the cau it the time, dat	ise(s) and manne e and place, and	er as stated. I due to the cause(s)
To the to the Complete	Me	29b. Signature and title of certification	m-N			29	c. License	number	1 U	290	J. Date signed (A	Month, Day, Year)
10		30. Name and address of person who	o gompleted cluse	of death (Iter	п 23а) (Туре.	Print)	3/	17.7	17 1 C=	1. + 0	h 12	1 4 - 2005
Sta Registra		31. Date filed (Month, Day, Year)	32 Re	gistrar's Signa	ature do	uli	1 6	V O'T	n	THEY S	rice () S	TOWNG TO WI

State of Maryland / Department of Health and Mental Hygiene 05 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Jeffrey Hunter Koscielniak February 05. 2005 02:27 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** University Hospital-Shock Trauma Baltimore 8. Date of Birth (Month, Day, Yea If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 DC 6. Sex 1 → M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Mar 4, Director 220-13-7453 18 Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Itema 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Severn Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 522 Wet Sand Drive 21144-2819 U.S.A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after onent of Health and Menial Hygiene. Int: If Item 27 is marked other than "natural", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify Ā 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Student College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carla Sue McLean Joseph Vincent Koscielniak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Joseph V. Koscielniak/father t of Health 522 Wet Sand Drive, Severn, MD 21144-2819 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State ö Depertment of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Feb 10,2005 Elkridge, MD 21. Signature Furniral Service License 22. Name and Address of Facility Singleton Funeral Home P.A. 1 Second Avenue S.W., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-transit Due to (or as a consequence of): physician a s the burial Box 68760. Physician/Medical The law requires that the death certificate attending p for use as IE FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 🗌 Yes 2 No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Ves 2 No 24a. Was an certificate hes birector, page 2 s autopsy performed 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1XYes 2 □ No 2X ER/Outpatient 3 DOA this 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Deceased anving 27. Manner of Death 28a. Date of Injury (Month, Day Year) After Certification: 5 Pending investigation 1 Natural 2 No death. 2 Accident 3 ☐ Suicide 40HM 1 Yes struck trees Director: 281. Location (Street and Number or Rural Route Number of City or Town, State) 800 BIL Rolling Rd Catorsville, MB 21228 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and O.C.M.E. February 05, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5.2 H106 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32#Registrar's Signature State Registrar FEB 0 8 2005

			For State Registrar	State of	f Marylan	•	artment			and M	ental Hyg		005		03683
			Negistrar Decedent's Name (First, Middle)	, Last)			imout				2. Date of Dea	ith		,	3. Time of Death
н	Physici		Kurt Kaldahl								Month 02-02	Day		ır	5:00a M
	/Medic Examin		4a. Facility Name (If not institution		n <i>ber)</i>		4b. City,	Fown, or	Location o	of Death			County of D	eath	J.Wa
			8006 Moorlan	nd Ave				hes				M	lontgo	mer	у
	Funeral		5. Social Security Number 466-94-7432	6. Sex 1√2√M 2□ F	7. Age (In yrs. 48		If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Birth	1 1 Yest	9. 8	Birthpla Countr	ace (State or Foreign Y) Florida
	Director		Usual Residence of Decedent	A. Z.	40	Yrs.					11-25-		3		riorida
	land ow		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10	d. Inside City Limits
	Mary Fired	ţō	MD Mon	tgomery	Ве	thesda									1 ☐ Yes 2 📉 No
	h the	irec	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What	Count	ry?
	72 hours after death with the Maryland natural; or Items 23a or 28a-f ehow disal Examinar must be notified at	Funeral Director	8006 Moorland	Ln					2081	L 4			USA		
	tems	n n	11. Marital Status	Armed Fo		.S. 13. \	Was Deced f Yes, spec	ent of Hi ify Cubai	spanic Ori n, Mexican	gin? (Spe i, Puerto	cify Yes or No- Rican, etc.)	1	4. Race - Al Black, W		
36	s afte		1 Never Married 2 Marr 3 Widowed 4 Divorced	ied 1 ☐ Yes If Yes, Giv Year or D	e		1 ☐ Yes 2	No In	Specify:				Specify:	Whi	te
21215-0036	tural	Completed by	15. Decedent			16a. Deced	dent's Usua	l Occupa	ation			16b, Kir	nd of Busine	ss/Indu	ustry
215	within 72 ene. than na	piet	(Specify only highes Elementary/Secondary (0-12)	t grade completed)	-40r 5+\	life. I	kind of wor DO NOT us	e retired,)						
212	giene grene er the	ĕ	12	College (1 4	401 01)	Soc	ial S	ecur	ity A	Admir	nistrat	Lon	Soci	al	Security
p	be filed stal Hygie of other event, II		17. Father's Name (First, Middle, Bernard A. Ka								(First, Middle, Thompso		Sumame)		
yla	2 should be and Mental Is marked reumatic ev	To Be						-							
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-1 show or other treumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relations	, , , , , ,		1					I Route Numbe				
e,	is 1 and 2 of Health a Item 27 Is other tree		Yuonne Kaldah 20a. Method of Disposition	1	20b. F	Place of Dispo	F Po	e of					ce Bea		NC 29582 m, State
nor	ages ont of t: If It		1 Burial 2 Scremation 4 Donation 5 Other (S)	3 □Removal from	State _	emetery, crer hesape				UN	2	Be	ltsvil	1e	MD
Baltimore,	permit. Pages Deportment of H Important: If Ite any Injury or of	1	21. Sign, ture of Furlerat Service		1/1		. Name an	d Addres	s of Facilit						
ã	Departing any ir		MANUE C	12401	Vark	2					emation ver Spri			10	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that c	aused the deat	h. Do not ent								,	Approximate interval Between
	Physician		Immediate Cause (Final disease or condition	70.1			off of		Corne	i Internaci					Onset and Death 20 years
	/Medical		resulting in death)		ired In orasaconseq		erici	ency	Sync	LEONE					20 years
	Examiner		Sequentially list conditions,	b. Diss	eminate	Mycob	acter	ium	Airun	n					5 months
1	ed sit	Examiner	il any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a ednesed	uence ory:									5
	and and al-tran	xan	that initiated events resulting in death) Last	c. Anem Due to	10 or as a conseq	uence of):								-	5 months
8760,	icate be executed physician and s the burial-transit	calE		d Aids	Wastin	ıg									6 months
89	ifficate g phy as the	Physician/Medical		U											
Вох	death certific e attending p id for use as f	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna		Ectopic pre	agnancy				2	3d. Date of		
	ne deat the att hed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of d		Other (spe						Month	L	Day Year
P.0	by by	Phy	9 Unknown			udaine in about			n in Dani I		220 Did to	hanna u	a a a a a stributa	to the	cause of death?
ŝ		by	Part II. Other significant condition	ris contributing to de	atii but not 195	diting in the u	idenying ca	ause give	in in Faiti.			es 2	_		bly 4 Unknown
orc	w requir been si should	etec			-										
Rec	e la has je 2	Completed									24a. Was a autop: perfor	sy med?	prior t death	o com	sy findings available pletion of cause of
Vital Records,		e Co	25. Was case referred to medical						OF Place	of Dooth	1 ☐ Yes		1 🗆 Y	es 2	!□ No
Ē	Physician: this certificaral director, I	To B	examiner? 1 Yes 2 No	Hospital:	npatient 2	ER/Outpatien	t 3 DO	A Othe			ne 5 AResid		□Other (Si	pecify)	
1 of	g Phy ter thi		27. Manner of Death	28a. Date		28b. Time of Injury		Bc. Injury Work	at		28d. Describe h			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
joi	Attending Frideath.	atio	1 Natural 5 ☐ Pendin investig	jation	,, 24y . 54.,	11.1,41.9	М.,		/es 2 □ i	No					
Division	I or Atten after deat Director: I in by the	ertification:	3 Suicide 6 Could r 4 Homicide determ	ined 286. Place	of Injury - At hing, etc. (Specif	ome, farm, str	eet, factory	, office		4	28f. Location (S City or Tow		Number or	Rural	Route Number,
	Hospital or 24 hours afte Funeral Dir tely filled in	O	200	P1 11 T 11											
	e Hospital 24 hours a e Funeral letely filled	edicai		g Physician: To the Examiner: On the ba											
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Med	29b. Signature and title of certifier				29c	License	number		2	9d. Date	signed (Mo	nth, Di	ay, Year)
}	F S F Ö		0 0 0 0 0 0	+111nn	Λ.	\sim		4:	277	8		02	2-02-2	005	,
			30. Name and appress of person	who completed caus	e of death (Iter	n 23a) (Type,	Print)		,	-					
	12		Lynette Pos				Ste 2	30 S	ilver	Spr	ing MD	2091	0		
	Sta		31. Date filed (Month, Day, Year)	32. R	egistra Signa	ature		A. 1							
	Registr	ar	FEB	0 8 2005	SCHOOL S	w St.	100	ES ES							

				1 - State Registrar	State of Ma	aryland /	Depa Cer	rtment of F tificate of	Health and M <i>Death</i>	ental Hy	giene 2	05	03684
				Decedent's Name (First, Middle, Last))					2. Date of De	ath	Yeer	3. Time of Death
		Physicia /Medic		Hazel C.	Kirkwoo	od				Februa			2:05 рм
		Examin	er	4a. Facility Name (If not institution, give Hospice of Baltimore-G	·	nter		4b. City, Town, o	or Location of Death			ty of Death	
		Funeral		5. Social Security Number 6. Se.	7. Age	e (In yrs. last b	irthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th	9 Rietho	lace (State or Foreign try)
		Director		213 10 3/3/]M 2 X [F	87	Yrs.	Morius Days	Hours Mill.	October	^{y, Yo} ar) 22, 1917	Maryl	änd
	land	MO M		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Tox	wn or Lo	cation				1	0d. Inside City Limits
	Man	a-f sh iffied	ctor	MD Baltimore	9	Ta	Meon						1 ☐ Yes 2X No
	di Tr	or 28	Director	10e. Street and Number				10f. Zip Code	ν.		10g. Citizen of		try?
	eath v	ns 23a	Funeral	7919 Ruxuay Road	12. Was Decedent I	Ever in U.S.	13. V	2120 Vas Decedent of H		cify Yes or No	U.S.A - 14. Ra	• ice - Americ	an Indian,
	036 urs after d	Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evant, or that the rectified at once.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		1	Yes, specify Cubi	Hispanic Origin? (Spe an, Mexican, Puerto I Specify:	Rican, etc.)	Spec	ack, White, o	etc. ite
10	5-0	natur	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	168	Deced (Give	lent's Usual Occup kind of work done	oation during most of workind)	ng	16b. Kind of I	Business/Inc	dustry
326	121 within	than than	Juno	Elementary/Secondary (0-12)	College (1-4or 5	+)		enaker	a)	100	Own 1	name	
7	d 2	Hygi other ant,	Be Co	17. Father's Name (First, Middle, Last)					18. Mother's Name	(First, Middle,	Maiden Surna	me)	
1	ylar ould be	Menta arkad atic ev	ToB	William Fletcher	Conney				Janet		Armstro		
3	Maryland 21215-0036	h and 7 is m		19a. Informant's Name/Relationship (T)					and Number or Rura			n, State, Zip	Code)
0	e and	Healt tam 2 othar		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of natory or other place	. D	ate	20c. Location	- City or To	wn, State
19,	Bage Page	nent o		1 XBurial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		* .	ley Mem'l		5	Timoni	.m, MD	
rrkwood	Baltimore,	Departr Imports any inj		21. Signature of Funeral Service Licens	∾ William G	. Dau			ess of Facility Ruc Road, Towson			Home,	Inc.
X				23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused ne cause on each lir	the death. Do	not ente	er the mode of dyir	ng, such as cardiac o	r respiratory a	rrest.		Approximate Interval Between Onset and Death
	E .	hysician		Immediate Cause (Final disease or condition resulting in death)	*	orrh		c st	oke			(CAYS
		/Medical xaminer		Tobaling in South	Due to (or as	a consequence	1	wion					years
			Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as	a donsequence	'						1
	ld lo	ind transil	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	s		-0						
,	60, A	physician and sthe burial-transit	al Ex	resuming in death) Last	Due to (or as	a consequence	9 OI);						
8	6876		edic		1								
7	Records, P.O. Box 6	the attending phed for use as	Physician/Medical	in the past 12 months? 1 Yes 2 No	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal deat		Ectopic pregnancy Other (specify)	у			ate of delive	ry D ay Year
10	P.O	been signed by the atte		9 ☐ Unknown ~ Part II. Other significant conditions co.		ut not resulting	in the ur	iderlying cause giv	ven in Part I.	23e. Did t	obacco use cor	ntribute to th	e cause of death?
3	ds,	signe Id be d	d by	Coronny A						10	res 2 No	3 Proba	ably 4 □Unknown
3	COL	shou	Completed		7					24a. Was			osy findings available
4	Re la	page 2	ome								rmed?	death?	npletion of cause of 2 No
	/ita	certificate has rector, page 2	Be	25. Was case referred to medical examiner?	lospital:			0#	26. Place of Death				11
	of \	n. After this certific funaral director,	. To	1 ☐ Yes 2 ☒ No	28a. Date of Injur	y 28b.	utpatien Time of	28c. Injur	ner: 4 ☐ Nursing Hor		dence 6 00t now injury occu	her (Specify	DIG Spice
	ion	ath. r: Afte e funa	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	Year)	Injury	Wor	rk?]Yes 2 □No				
	Division of Vital Records,	safter des Diractor d in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.		farm, stre	eet, factory, office	2	28f. Location (3 City or Tox	Street and Num vn, State)	ber or Rura	l Route Number,
	e Hospits	within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, is	Medical C			examination a			me, date and place, a opinion, death occurre				
	Toth		Me	29b. Signature and title of pertifier	ny iZe	ley.	m		5205		29d. Date sign	Ary 4	4,2005
		10		W. A. Riley	GBMC	1/- 21	(Туре,	Charle	es St. Bo	elto.v	nd 2	120	۶
		Sta Registr		31. Date filed (Month, De) (1987) 8	2005 ^{22. Regist}	ar's Signature	H.	fort					

Box 68760,	
, P.O.	
Records	
f Vital	
Division of	

		Plea	se Type or Pri					•		gible.	
	•	For State Registrar	State of M	aryland /	•	rificate of	lealth and N Death		Jiene 2	005	03685
Physicia: /Medica	n	Decedent's Name (First, Middle RICHAR		RWIN			CHIN	2. Date of Dea Month FEBRUAF	RY 02,		3. Time of Death 06:45P M
Examine	r	4a. Facility Name (If not institution VA MARYLAND HEA	ALTH CARE SYS			PERRY P			CEC	nty of Death	
Funeral Director		5. Social Security Number 054-20-7320 Usual Residence of Decedent	6. Sex 7. Ag	e (In yrs. last t	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	JUL.2,	927	9. Birth	place (State or Foreign NY
Maryland		10a. State 10b. County	HARFORD	10c. City, To	wn or Loca BEL A						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
death with the Maryland ms 23s or 28e-f show must be notified at	5	10e. Street and Number 1408 BONNETT			DEL A	10f. Zip Code	21015		10g. Citizen	of What Cou	untry?
	by Fur	11. Marital Status 1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces?	Ever in U.S.		as Decedent of H Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White	
permit. Pages 1 and 2 should be filed within 72 hours after Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Its eny injury or other treumatic event. Le Mudical Exame on once.	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)		5+1	(Give kı life. De	nt's Usual Occup ind of work done O NOT use retired	during most of work d)	ing		f Business/li	
filed v Hygie other t		17. Father's Name (First, Middle,			MECHA	NICAL E	18. Mother's Nam	e (First, Middle,			1
Wental Mental rrked o	0 00	HENRY	WALLACE	1	KOLCH	IN	JEANNE'	TTE			SIEGEL
and 2 should salth and Mer n 27 is marke		19a. Informant's Name/Relations BEATRICE KOLC			1408	BONNETT	and Number or Rur PLACE -	UNIT D	BEL	AIR, N	1D 21015
Pages 1 ment of Ho ant: if Iter ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S _i		20b. Place cemet	tery, crema	tion (Name of atory or other place WISH CEI		6/2005	20c. Location ROS	EDALE ,	
permit. Depertimports ony inj		21. Signature of Funeral Service	Licensee	>			ss of Facility SO				
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each li	the death. Do						ıcc.,	Approximate Interval Between Onset and Death
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		SON DIS				<u>. </u>		1	UNKNOWN
	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	AER'S D		SE					UNKNOWN
be bur	al Examiner	resulting in death) Last		a consequence	e of):						
tificate ig phys as the	ealc		d								
The law requires that the death certificate the has been signed by the ettending physpage 2 should be detached for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal deal		ctopic pregnancy Other <i>(specify)</i>	/			Date of deliv Month	ery Day Year
		Part II. Other significant condition	ons contributing to death b	ut not resulting	in the und	lerlying cause giv	ren in Part I.		bacco use c es 2 □ No		he cause of death?
	Completed							24a. Was a autops perform	sv	b. Were auto prior to co death? 1 \(\text{Yes}	opsy findings available impletion of cause of
certificate		25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatie	ent 2 ER/C	D., 4 4 4	3CI pos Oth	26. Place of Deat	h <i>(Check only or</i> me 5 ☐ Reside		Dale (0	
선 보는	- 1	27. Manner of Death 1 XNatural 5 Pendin 2 Accident investig	28a. Date of Inju (Month, Da	ry 28b.	. Time of Injury	28c. Injur Wor M 1	v at	28d. Describe h			y/
a di ji	Ceruncation:	3 Suicide 6 Could r 4 Homicide determ	ined 286. Place of Inj	ury - At home, c. (Specify)	farm, stree	t, factory, office		28f. Location (Si City or Town	treet and Nu n, State)	mber or Rur	al Route Number,
Hospi 4 hou Funer ely fill	Medical	29a. Certifier 1 X Certifyin (Check only one)	g Physician: To the best Examiner: On the basis of and manner sta	f examination a	ge, death o and/or inve	occurred at the tir stigation, in my o	ne, date and place, pinion, death occuri	and due to the cred at the time, d	ause(s) and ate and plac	manner as s e, and due t	stated. o the cause(s)
F 3 F 8	Σ	29b. Signature and title of certifier	Shop			29c. Licens		2	9d. Date sig	ned (Month,	
0		30. Name and address of person				rint)		Danos	DOTAGE	ME	21002
State Registra		SURESH SHANDELY 31. Date filed (Month, Day, Year)	32. Registr	ar's Signature		EALTH CA	RE SYSTEM	, PERRY	POTNI	, PID a	<u> </u>
		75R ()	X 7005 700	Scient L	10	18842					

			1- State of Maryland / Dep	artment of Health and M rtificate of Death		ene 2005	03686
			Decedent's Name (First, Middle, Last)		2. Date of Death	g. 140.	3. Time of Death
	Physici /Medic	al	PETERSON G KIN		02 0	Day Year 4 2005	12:30P M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		ζ.	45 Linwood Avenue	Glen Burnie		Baltimor	
l.	Funeral Director		5. Social Security Number 216 18 5595 6. Sex 1 M 2 F 86 Yrs.	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,) 07 25 1	(ear) 9. Birtho Cour 918 Mar	elace (State or Foreign etry) yland
	pui 🛦		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			Od. Inside City Limits
	Marylis 9-f sho	Director	MD Baltimore Glen Burn				1 ☐ Yes 2 No
	n the	lre	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cour	itry?
	h wit	<u>E</u>	45 Linwood Avenue	21061		USA	
21215-0036	be filed within 72 hours after death with the Maryland ald Hygiene. Ald Hygiene. ad other then "natural", or flams 23c or 28e-f show event, the Medical Ever's er must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Married 11. Was Decedent Ever in U.S. Armed Forces? 1 Yes Give 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes Give 13. Was Decedent Ever in U.S. Armed Forces? 1 Yes Give 14. Was Decedent Ever in U.S. Armed Forces? 1 Yes Give 15. Was Decedent Ever in U.S. Armed Forces? 1 Yes Give 16. Was Decedent Ever in U.S. Armed Forces? 1 Yes Give 16. Was Decedent Ever in U.S. Armed Forces? 1 Yes Give 1 Yes Give	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	city Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
9	2 ho	ted		dent's Usual Occupation	16	6b. Kind of Business/In	dustry
215	hin 7	ple	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)	rg Fr	ank J. Faf	azza and
21	filed withii Hygiene. othar than ant, Ire M	Completed		penter		Sons	
	be filed tal Hygid d other event, L	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name			
Maryland	2 should be and Mental is marked o	ToE	Thomas King	Elizabet	h Boffor	rd 	
Jar	s 1 and 2 should f Health and Men itam 27 is marke other traumatic			ng Address (Street and Number or Rura			Code)
	s 1 and 2 f Health itam 27 other tra			Linwood Avenue, Gle			
more	Pages 1 nent of H int: If ita iry or ot		20a. Method of Disposition 1	matory or other place)		Elkridge,	
Baltimore,	permit. Pages Department of Important: If if any injury or c		21. Signature of Funeral Service Lice see	2. Name and Address of FacilityGary	L. Kauf Park	man Funera	l Home at
	40 = # Q		()	250 Washington Blvd	L. Elkri	dge, MD 21	061
	* * *		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac o	r respiratory arres	t,	Approximate Interval Between Onset and Death
	Priysician	9 /	Immediate Cause (Final disease or condition resulting in death)	ARDIAL ZNEA	12CTIC	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	
9	/Medical Examiner		Due to (or as a consequence of):	1 1. 1			es.
	3 3	_	Sequentially list conditions, if any leading to immediate	ANTERY D	ISEAS	3.	SYEARS
	ted nsit	ulu ulu	cause. Enter Underlying	C. A.C		120	X VEND S
	al-tra	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last c. HYPERTEN Due to (or as a consequence of):	3/01/			-0 yzarz
8760,	cate be executed obysician and the burial-transit	dlcal					
89	flicate g phy as the	edic	V				
O. Box	at the death certificate be executed by the attending physician and trached for use as the burral-transit	Physician/M		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ny Day Year
S, P.	gned go de	by	Part II. Other significant conditions contributing to death but not resulting in the to	- j	1.1	cco use contribute to the	
ord	w require been signature	ted	ATRIAL FIBICILLATIO		1 Yes	2 No 3 Prob	ably 4_Duaknown
Records,	e law r has be ge 2 sh	Completed	PROSTATE CANCER		24a. Was an autopsy	prior to cor	osy findings available npletion of cause of
H		Co	GOUT		performe		21 No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
of \	Physic this c	၉	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	The second secon	ne 5 nesidend	ce 6 ☐Other (Specify)
	ding P h. After t funera	on:	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury 28b. Time of Injury Injury	Work?	8d. Describe how	injury occurred	
Sio	Attanding or death. actor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be again place of Injury. At home, farm of	M 1 ☐ Yes 2 ☐ No			
Division	o tte	Certification;	4 Homicide determined determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 2	281. Location (Street City or Town, S	et and Number or Rura State)	l Route Number,
	To the Hospital within 24 hours a To the Funaral C completely filled		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or in	h occurred at the time, date and place, a	nd due to the caus	se(s) and manner as st	ated.
	thin 24 thin 24 the F	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number		I. Date signed (Month, I	
	¥ 5 8		1/10/- 25/1	LIS DOSCIO	/		17 700 /
	10		30. Name and address of person who completed cause of death (Item 23a) (Type,	71 202314 Print) -		BRUARY	1 6005
	V		RICHARDS FISHER CRAIN	N TOWERS C	120 B	11011157	1D 20061
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	70	10	0.21	
	Registr		FEB 0 8 2005	rast s			

Dharis		1 - State Unpend Ite Registrar 1. Decedent's Name (First, Middl			Certificate of	Death	2. Date of De	ath Day	Year	0 3 6 8 7
Physicia /Medic	al	Christophe 4a. Facility Name (If not institution		um	Ab City Town	or Location of Death	Januar	 	2005	
amin	er	531 North Pula	-			imore		40. 00	N/A	
al or		5. Social Security Number 217-84-0872 Usual Residence of Decedent	6. Sex 7. Ag	e (In yrs. last bi	virthday) If Under 1 Year Yrs. Months Days		8. Date of Bir (Month, Da July 1		MG	hplace (State or Fore Tyland
	ctor	10a. State 10b. County MD N/A			wn or Location					10d. Inside City Lim
	ai Dire	10e. Street and Number 531 N. Pulaski	Street		10f. Zip Code 21223			-	n of What Co d State	ountry? es of Amei
	Completed by Funeral Director	11. Marital Status To Never Married 2 Mar 3 Widowed 4 Divorced	IT Yes, GIVE		13. Was Decedent of I If Yes, specify Cub		pecify Yes or No o Rican, etc.)	i	Race - Ame Black, White pecify: B1	e, etc.
	pieted	15. Deceder	nt's Education est grade completed)		a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of wor	king		of Business/	
	Be Com	12 17. Father's Name (First, Middle,	0	S	Sky Cap	18. Mother's Nan	ne (First, Middle			ndustry
	To B	Christopher	Gordon Jr.				th Lan			
		19a. Informant's Name/Relations Ginger Howar 20a. Method of Disposition	(()†	tice	Bb. Mailing Address (Street BWI Cargo Bu: of Disposition (Name of eary, crematory or other pla awn Cemetery			timore		vland 2124
ند ند		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5	Specify)	Wood1		, , , , ,				Maryland Directors
OUCE		> Churchen	leso_							yland 2113
		Immediate Cause (Final disease or condition		_{rmia} Con	not enter the mode of dysenset by mplicated By					Approximate Interval Between Onset and Death
	edicai Examiner	Immediate Cause (Final	a. Hypother Due to (or as b. Due to (or as c.	ne.	mplicated By e of):					Approximate Interval Between Onset and Death
	Ĕ	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Hypothe: Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome	rmia Con a consequence a consequence a consequence of pregnancy 2 Fetal deat	mplicated By e of): e of): e of):	Bronchop		a	d. Date of del Month	Interval Between Onset and Death
	by Physician/Medical Ex	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \)	a. Hypother Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	rmia Consequence a consequence a consequence a consequence of pregnancy consequence consequence consequence consequence	mplicated By e of): e of): th 3 □Ectopic pregnanc 5 □ Other (specify) □	Bronchop	Oneumoni 23e. Did	a 234	Month	Interval Between Onset and Death
	Completed by Physician/Medical Ex	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Hypothe: Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown ions contributing to death to	rmia Consequence a consequence a consequence a consequence of pregnancy consequence consequence consequence consequence	mplicated By e of): e of): th 3 □Ectopic pregnanc 5 □ Other (specify) □	Pronchop Ey Ey Even in Part I.	23e. Did 1 □ 24a. Was auto	tobacco use Yes 2 san psy ormed? 2 No	Month contribute to No 3 □ Pr	ivery Day Year othe cause of death? obably 4 Dunkno
al	Be Completed by Physician/Medical Ex	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Hypothe: Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown ions contributing to death to	rmia Consequence a consequence a consequence a consequence of pregnancy consequence consequence consequence consequence	mplicated By e of): e of): th 3 Ectopic pregnance 5 Other (specify) g in the underlying cause gi	Pronchop Ey Ey Eyen in Part I. 26. Place of Dec	23e. Did 1 □ 24a. Was auto	tobacco use Yes 2 s an ipsy ormed? 2 No one)	Month contribute to No 3 pr 24b. Were au prior to death? 1 77 Yes	ivery Day Year Dobably 4 Dunknow utopsy findings availate completion of cause
	To Be Completed by Physician/Medical Ex	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Hypothe: Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown ions contributing to death be al Hospital: 1 Inpati 28a. Date of Inj (Month, De	rmia Consequence a consequence a consequence a consequence a consequence a consequence b of pregnancy 2 Fetal death b out not resulting and the consequence b of pregnancy 2 Fetal death b out not resulting and the consequence b of pregnancy 2 Fetal death b out not resulting and the consequence b of pregnancy 2 Fetal death b out not resulting b out not resulting and the consequence b of pregnancy 2 Fetal death b out not resulting b out not resulting and the consequence b of pregnancy 2 Fetal death b out not resulting b out not resulting and the consequence b of pregnancy 2 Fetal death b out not resulting	mplicated By e of): e of): th 3 Ectopic pregnant 5 Other (specify) g in the underlying cause given the underlying cause	Pronchop 29 Wen in Part I. 26. Place of Deather: 4 \(\text{Nursing H} \) 17 at lock? 17 45 2 \(\text{Y} \) No	23e. Did 1 24a. Was auto perful 1 24f. Check only dome 5 Res 28d. Describe	tobacco use Yes 2 s an ipsy ormed? 2 No one) idence 6 [how injury of	Month contribute to No 3 pr 24b. Were au prior to death? 1 Wes Mother (Spe	ivery Day Year Dably 4 Unknowtopsy findings availacompletion of cause
	To Be Completed by Physician/Medical Ex	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Hypothe: Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown ions contributing to death be al Hospital: 1 Inpati 28a. Date of Inj (Month, De	rmia Consequence a consequence a consequence a consequence a consequence a consequence b of pregnancy 2 Fetal death b out not resulting and the consequence b of pregnancy 2 Fetal death b out not resulting and the consequence b of pregnancy 2 Fetal death b out not resulting and the consequence b of pregnancy 2 Fetal death b out not resulting b out not resulting and the consequence b of pregnancy 2 Fetal death b out not resulting b out not resulting and the consequence b of pregnancy 2 Fetal death b out not resulting b out not resulting and the consequence b of pregnancy 2 Fetal death b out not resulting	mplicated By e of): e of): th 3 Ectopic pregnant 5 Other (specify) g in the underlying cause gi	Pronchop 29 Wen in Part I. 26. Place of Deather: 4 \(\text{Nursing H} \) 17 at lock? 17 45 2 \(\text{Y} \) No	23e. Did 1 □ 24a. Was auto perficience of the control of the contr	tobacco use Yes 2 san psy 2 No one) idence 6 [how injury of wm, State) State)	Month contribute to contribute to No 3 pr 24b. Were au prior to death? 1 yres Cother (Specoccurred	ivery Day Year or the cause of death? robably 4 Dunknoutopsy findings availacompletion of cause 2 No
	Certification: To Be Completed by Physician/Medical Ex	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions are underlying in death Value a. Hypothe: Due to (or as b. Due to (or as c. Due to (or as d. Due to (or as d. Due to (or as d. Pregnant a g Unknown ions contributing to death to ling tigation d not be mined A. Due to (or as 1	ent 2 ER/Cury 28b. 2 of my knowledge of examination a	mplicated By e of): e of): th 3 Ectopic pregnant 5 Other (specify) gin the underlying cause ging the underlyi	ven in Part I. 26. Place of Deather: 4 \(\text{Nursing H} \) 1/4 y at 1/2 xt 1/4 y at 2 \(\text{Y} \) No	23e. Did 1 24a. Was auto perfusive for To Baltimo	tobacco use Yes 2 san psy one) idence 6 [how injury of win, State) The cause(s) are cause(s) are tobacco use Yes 2 line (Street and injury of win, State) Cause(s) are cause(s) are tobacco use The cause(s) are The cause(s) are tobacco use The cause(s) are The cause(s) are tobacco use The caus	Month contribute to No 3 pr 24b. Were au prior to death? 1 yres Cother (Specoccurred	ivery Day Tear Onset and Death	
. To the Funeral Director: After this certificate has been signed by the attending physician and the property of the property	To Be Completed by Physician/Medical Ex	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Hypothe: Due to (or as b. Due to (or as c. Due to (or as d. 4 Pregnant a gl Unknown dions contributing to death be all Hospital: 1 Inpati ing tigation of not be mined 28a. Date of Inj (Month, De Contribution of the best of the building, e Scene ing Physician: To the best of the	rmia Col a consequence a consequence a consequence a consequence a consequence a consequence b of pregnancy 2 Fetal deat t time of death but not resulting ent 2 ER/C ury ay Year) jury - At home, tc. (Specify) of my knowled of examination a lated.	mplicated By e of): e of): th 3 Ectopic pregnand 5 Other (specify) g in the underlying cause group of the underlying cause group of the underlying cause group of the underlying cause group of the underlying cause group of the underlying cause group of the underlying cause group of the underlying cause group of the underlying cause group of the underlying cause group of the underlying cause group of the underlying cause group of the underlying cause group of the underlying of the under	ven in Part I. 26. Place of Deather: 4 \(\text{Nursing H} \) 1/4 y at 1/2 xt 1/4 y at 2 \(\text{Y} \) No	23e. Did 1 24a. Was auto perfusive for To Baltimo	tobacco use Yes 2 san ppsy ormed? 2 No one) idence 6 [how injury of win, State) Core, M cause(s) ar date and p	Month contribute to No 3 pr 24b. Were au prior to death? 1 pres Other (Spen occurred	ivery Day Year of the cause of death robably 4 Dunkni utopsy findings avail completion of cause 2 No cify) SCENE unk ural Route Number, Pulaski S s stated. e to the cause(s) h, Day, Year)

ORIGINAL

			For State Registrar	State of N	Maryland		artment of tificate o			-	giene	05 (3688
	Physici	an	1. Decedent's Name (First, Midd	le, Last)						2. Date of De	ath Day	Year	3. Time ol Death
	Physici /Medic		ESSIE		WRY	/				Feb	2	2005	605 M
	Examir	er	4a. Facility Name (If not institution		er)	-A a	4b. City, Town			_		inty of Death	1
	·		GOOD SAMA) 5. Social Security Number	21"TAN F 6. Sex 7.	Age (In yrs. las	t hirthday)	If Under 1 Yea	ALTIN r If Under	- '	_		TIMORI	lace (State or Foreign
	Funeral Director		578-34-5472	1 □ M 2 🔀 F	82	Yrs.	Months Day		Min.	8. Date of Bir (Month, Da 2-3-2		Coun	S.C.
	P.		Usual Residence of Decedent	1									
	the Marylar 28a-f show	-	10a. State 10b. County	,	10c. City,	Town or Lo						11	0d. Inside City Limits 1X Yes 2 □ No
	he M	ecto	Md. NA				Baltimo						
	72 hours after death with the Maryland neturel', or items 23e or 28a-f show disal Examil vermal terminal of	Funeral Director	503 Chateau A	venue			10f. Zip Code	212			-	of What Coun JSA	try?
	items 23e	eral	11. Marital Status	12. Was Decede	nt Ever in U.S.	13.			igin? (Sp	ecify Yes or No	- 14.1	Race - America	an Indian.
9	or iter	Fun	1 ☐ Never Married 2 ☐ Mar	ried 1 Yes 2		1	Was Decedent of Yes, specify Cu			Rican, etc.)		Black, White, e	etc.
93	ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Date	s:		I□Yes 2√N	o Specify:			Spe	ecity: Bla	ck
215-0036	"nett	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)		16a. Deced (Give	lent's Usual Occ kind of work don DO NOT use reti	upation e <i>during</i> mos	st of work	ing	16b. Kind o	f Business/Ind	lustry
121	filed within Hygiene. Ither than "	dmo	Elementary/Secondary (0-12)	College (1-4d	or 5+)			·ea)			Othor	r Peopl	e Homes
d 21	filed with Hygiene. other than		8th grade 17. Father's Name (First, Middle,	Last)		DOM	estic	18. Moth	er's Name	a (First, Middle,	Maiden Sun	name)	e monies
an	Mental Mental arked o	To Be	John	Wherr	Ÿ			Su	ısie			Walls	
Maryland	2 should and Men Is marke eumatic	-	19a. Informant's Name/Relations	ship (Type, Print)			g Address (Stre						
	1 and 2 Health em 27 I		Shirley West	Daughter			St. Tho	mas Av	7e.,	Baltimo	ore, Mo	d. 212	.06
3altimore,	S to I		20a. Method of Disposition 1 Burial 2 Cremation	3 □Removal from Sta	COTT	ce of Dispo netery, crer	sition (Name of natory or other p	ace)	2-10	Date 1-05	20c. Location	on - City or To	wn, State
Ë	tmen tent:		'4 Donation 5 □ Other (S	Specify)		-	ove Bapt				Ches	ter Co	., S.C.
Bal	permit. Pag Department Importent: f any injury o	19	21 Signatur of Funeral Service	Kualt	vy. 9	22	. Name and Add March		•	Bal1 110	imore L E. N	, Md. orth Av	21202 re.
			23a. Paryl. Enter the disease, o shock, or heart lailure. Lis	r complications that caus t only one cause on each	sed the death.	Do not ent	er the mode of d	ring, such as	cardiac (or respiratory a	rest.		Approximate Interval Between
	Physician		Immediate Cause (Final di Jay or condition	ACUT	E M	YOC+	FDIAL	10	FAI	CTION	1		Onset and Death
	/Medical Examiner		retuling in death)	ue to (or	as a conseque	nce of):				761			
		5	Sequentially list conditions, if any leading to immediate	Due to (or	as a conseque	POT	C CA	ROLDY	1450	ULAR	- Dist	450	
	nted Insit	i i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	K									
Ć	execu in and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or	as a conseque	nce of):							
8760,	cate be executed oblysician and the burial-transit	cal		d									
9	ntifica ng ph as th	Ved	IF FEMALE:								1	İ	
Вох	The law requires that the death certifica tte has been signed by the attending phage 2 should be detached for use as it	Physician/Medical	23b. Was decedent pregnant in the past 12 months?		2 Fetal de	eath 3	Ectopic pregnan	су				Date of deliver	y Day Year
0	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of deal	th 5 □	Other (specify)					Wildfull	Day
Δ.	that the de ed by the detached		Part II. Other significant conditi	ons contributing to death	n but not resulti	na in the u	nderlying cause of	iven in Part I		23e. Did to	obacco use c	ontribute to the	e cause of death?
Records,	uires tha signed I	d by					, ,			101	res 2 No	3 ☐ Proba	ably 4 Unknown
00	w require been si should b	lete								24a. Was	an 24	b Were auton	sy findings available
Re	Physician: The lav this certificate has al director, page 2	Completed								autop	rmed?	prior to com death?	rpletion of cause of
Vital		a	25. Was case referred to medica	ıl	330			26. Place	ol Death	1 Yes	ne)	1 ☐ Yes	2□ No
*	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa	atient 2	Outpatien	t 3□ DOA C	et.		me 5 Resid		Other (Specify))
n of		ü	27. Manner of eath 1 Natural 5 □ Pendi	28a. Date of I	njury 28 Day Year)	8b. Time of Injury	28c. Inj W			28d. Describe h			
Sio	Attending r death. sctor: After by the fune	catle		igation				Yes 2	No				
Division	or At or At Direct in by	Certification:	4 Homicide determ	nined 286. Place of	Injury - At home etc. (Specify)	e, larm, str	et, factory, office	•		28I. Location (S City or Tox	Street and Nu vn, State)	mber or Rural	Route Number,
	Hospital or Attend 24 hours after death Funerel Director: tely filled in by the	Ce	29a. Certifier Certifyi	ng Physician: To the be	et of my knowle	nda doeth	one weed at the		d elece				
	To the Hospital or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical	Examiner: On the basis	s of examination	n and/or inv	restigation, in my	opinion, dea	th occurr	ed at the time,	date and plac	mammer as sta se, and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie	er /			29c. Lice	nse number				ned (Month, E	
	1 /	10) X	7/	MD		DE	89 2	3		teb	2,20	05 08E MD2129
1	1			o co pleted cause o	of death (Item 2	За) (Туре,	Print)						
<i>_</i>	11		KER ICTH =	TESEPH	MD	- 56	OL LOG	+ RAV	EN	BLW	0 . 7	ALTIMO	PE MD21239
	Sta Regista	7.7	31. Date filed (Month, Day, Year	32. Regi	strår's Signatur	9	6 . 10						,
DH	MH 17 Rev 1/2	38	FEB	32. Regi	Elgens	D.	A STATE OF THE STA						

ORIGINAL

			1 - For State Registrar	State of Ma			ent of Ho		d Mental Hy	giene	11115	03689
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) ADDIE MA	Y	LUMB				2. Date of De Month FEBRUA		2 2005	3. Time of Death 14:57 M
	Examin		4a. Facility Name (If not institution, give stra HARBOR HOSPITAL			В	ALTIMO				County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 Number 213-34-4319 Usual Residence of Decedent	20 7 F	e (In yrs. last birth 68 Y	Monti	der 1 Year ns Days	If Under 24 H	1rs. 8. Date of Bir (Month, Da	y, Year)		place (State or Foreign intry) Vland
	ne Maryland Ba-f show offilied at	ector	10a. State 10b. County Maryland n/a		10c. City, Town Balti	more						10d. Inside City Limits 1 Yes 2 No
	ath with the 23e or 2	Funeral Director	10e. Street and Number 1446 Riverside Ave				Zip Code 21230			_	zen of What Cou ted Stat	•
036	within 72 hours after death with the Maryland ane. than "netural", or items 23e or 28a-f show he Medical Evantirar maal be notified at	Þ	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent 8 Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	Ever in U.S. No	If Yes, s	cedent of His specify Cubar s 2/1 No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No lerto Rican, etc.)		14. Race - Ameri Black, White Specify:	
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. ad other than "natural", or items 23e or 28a-f show or other than "natural", or event, the Medical Examiner must be notified at	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	ion <i>ompl</i> eted) College (1-4or 5	i+) (Give kind of	T use retired)	uring most of	working		nd of Business/Ir	ndustry
yland 2	2 should be filed within and Mental Hygiene. is marked other than aumetic event, the Me	To Be C	/ years 17. Father's Name (First, Middle, Last) Clyde R. Stewart			шешаке			Name (First, Middle, atie Sasa	Maiden		
, Mar	uses 1 and 2 should to f Health and Mer if item 27 is marke or other traumetic		19a. Informant's Name/Relationship (Type Charles D. Lumb, St			_			Baltimor			21230
imore	permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other tra once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify)	noval from State	20b. Place of I cemetery Cedar	, crematory o Hill (crother place Cemete:	$ry \mid 2-1$		Bro	cation - City or T oklyn Pa	
Ball	permit Depart Import any in			ayne Ost		130 1	s. For	t Ave.	Funeral Baltimore	e, M	P.A. 21230)
STATE OF THE PARTY	Fnysician /Medical Examiner	ler	234. Part1. Enter the disease, or complica shock, or hear failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate.	Hypey Dy tokor as	a consequence of	e Av			Cardiov		Inv Disease	Approximate Interval Between Onset and Death
68760,	death certificate be executed e attending physician and ad for use as the burial transit	edical Examiner	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as	a consequence of	f):						
.O. Box	the y th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopii 5 □ Other	c pregnancy (specify)			2	23d. Date of deliv Month	rery Day Year
ords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contribute Seizing in the	buting to death but	ut not resulting in	the <i>u</i> nderlyin	g cause give	n in Part I.	23e. Did t		se contribute to t	the cause of death?
Vital Records,	The law ate has b page 2 sl	Completed	0						24a. Was autor perfo 1 Yes		24b. Were auto prior to co death? 1 □ Yes	opsy findings available ompletion of cause of
Division of Vita	ing Phys	ation: To Be	Tes 22No	pital: 1 □ Inpatie 28a. Date of Injui (Month, Daj			DOA Other	r: 4 🗆 Nursin	Death Check on og Home 5 Resident Resid	dence 6		fy)
Divis	tal or Attend rs after death al Director: , ed in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulg. etc.	ury - At home, farr c. (Specify)	m, street, fac	tory, office		28f. Location (S City or Tou			al Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	ian: To the best of c: On the basis of and manner sta	examination and	death occur or investigat	ed at the time ion, in my op	e, date and plainion, death o	ace, and due to the courred at the time,	cause(s) date and	and manner as s place, and due t	stated. to the cause(s)
)	To the I within 2: To the I complet	Σ	29b. Signature about 19 of confiner				29c. License	number 3	•		e signed (Month,	CHARLES
	5		Jorge Vallecil	1	eath (Item 23a) (T	_ 1	ht?	3. 6	paltimo	re	mD	21230
	Sta Registi		31. Date filed (Month, Day, Year) FFR 0 8 2005	2. Registra	ar's Signaure	porti	-			1		

		1- For Amend Item 1 pertaph of Many and 8 Dep	artigent of Health and N rtificate of Death	ental Hygie	Marie Mr. Co. Co.	03690
DI		Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
Physicia /Medica		Long Nelda Elaine Lo	ong	Jan. 3	Day Year 1 2005	5:45 A M
Examine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	7	4c. County of Dea	
		North Pine Assisted Living	Manchester		Carroll	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yo	ear) (C	thplace (State or Foreign
	-	217-24-5067 X 77 Usual Residence of Decedent		Sept.17	1927	MD
land		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
Many if sh	ò	MD Carroll Westmin				1 ☐ Yes 2 ⊋No
the	Director	MD Carroll Westmin 10e. Street and Number	10f. Zip Code	10a	. Citizen of What Co	ountry?
With With		2738 Fridinger Mill Rd.	21157		USA	,
na 2:	Funeral	11. Maritat Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame	erican Indian.
tter ltar	=	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Xes 2 ☐ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whit	e, etc.
urs a	۾	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify:	white
72 hours "natural",	Completed	15. Decedent's Education 16a. Dec	dent's Usual Occupation	16	b. Kind of Business	/Industry
hin 7	pie	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired) -	king		,
d with	E O	12 1 Secre	etary		Bendix	
be filed within 72 hc fall Hygiene. d other than "nature event, ITE M. ALE.	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	iden Surname)	
should be filed within the Mental Hygiene. marked other than matic event, ITE M	9	Homer M. Heacock	Kathe	rine Klas	s	
		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ing Address (Street and Number or Rui	ral Route Number, C	ity or Town, State,	Zip Code)
and 2 ealth a n 27 le		JoAnn Hunter/sister 273	8 Fridinger Mill R	d. West	minster.	MD 21157
Jes 1 and 2 of Health of Itam 27 I		20a. Method of Disposition 20b. Place of Disposition	osition (Name of	Date 20d	c. Location - City or	
Pages nent of J int: If Its		1 Sourial 2 Cremation 3 Chemoval from State	Episcopal Church	3/05 Cem	Long Gre	en MD
permit. Pages Department of Important: If Is any Injury or o		21. Signature of Europa Service accounsee	2. Name and Address of Facility		S	
P P P P P P P P P P P P P P P P P P P	,	Michael J. Flagle	Lemmon Funeral H O W. Padonia Rd.	ome of Du	ulaney Va	illey, Inc.
		23a. Part1. Enter the disease, or complications that caused the death. Do not en				Approximate
District		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	7			Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	4			
Examiner		Due to [or as a consequence of]:				
	e.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a or nsequence of):	ρŊ			
peti nsit	ž E	cause. Enter Underlying Cause (Disease or injury	Ara 20			
y xecu al-tra	Examin	that initiated events resulting in death) Last C. Due to (or as a consequence of):	rua			
			,			
phy cate	dicai	d				
Physicien: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of de	livan
atter atter	Physician/M	in the past 12 months 1 Live birth 2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
the d	ysic	1 Yes 2 Like 9 Unknown 9 Unknown				
that the de ded by the a		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23a. Did tobac	co use contribute to	the cause of death?
signed I	l by	, , , , , , , , , , , , , , , , , , ,	, g	1 ☐ Yes		obably 4 Dunknown
w require	etec			-		
has h	Completed			24a. Was an autopsy	prior to	utopsy findings available completion of cause of
Physiclen: The this certificate his al director, page	Co			performed		2 □ No
siclen: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		h (Check only one)		
Physic this of all directions of the contractions of the contracti	٩	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		ome 5 Residenc	e 6 Ver (Spe	city) AL
e de la company	on:	27. Manner of Death 1	Work?	28d. Describe how	intury occurred	
endi eath.	cati	2 Accident investigation	M 1 Yes 2 No			
or Attendation of Attendation of Attendation of Attendation of the cross of the cro	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S		ural Route Number,
ital of rational property of the rational property is a few of the rational property of the rati						
dosp 4 hou une ely fil	cal	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check only 2 Medical Examiner: On the basis of examination and/or in the basis of e	th occurred at the time, date and place,	and due to the caus	e(s) and manner as	s stated.
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medic					
To To Toon	2	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Mont	h, Day, Year)
X		THE WIND	D-0034	< 18 0	1-31-6	27
0		30. Name and address of person who completed cause of death (Item 23a) (Type	29c. License number D-0054 Print) Malcalm dune		~.	13 7114
C		DK Kamen 1. Kahene 3491	ralcolm dune	Warti	renster P	10 215m
Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Les .			
Registra	ar	FFR U & CUUD ARRIVAL AT A POPULATION OF THE POPU				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item#17,19a, perFH, 6840, 2/8/05 TI
For State of Maryland / Department of Health and Mental Hygiene 05

PER INF G841 4 Pertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 02, **Physician** 2005 Antonio 11:45 A^M CWON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Sop 1 9-02-1701 1 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2□F Director Yrs. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or L 10d. Inside City Limits item 27 is marked other then "naturel", or items 23a or 28a-f show other treumatic event, the Mudical Examinar must be notified at Director 1 Yes 2 No MD 10e. Street and Number 10g. Citizen of What Country? 21206 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 and 2 should be filed within 72 hours after of the should and Mental Hygiene. Heelth and Mental Hygiene. Sm 27 is marked other then "naturel", or ite Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No BIACK Specify! 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ary/Secondary (0-12) College (1-4or5+) Cochier 17 (Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Suman Be Nadine Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Heelth at Importent: If Item 27 is any injury or other treu once. Kandallstown, MD, 20b. Place of Disposition (Name of rametery, crematory or other place) 20a. Method of Disposition Date Comptery, crematory or of the Compte Burial 2 Cremation 3 Removal from State taltimore **4** □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Voucan Greene Funeral Sive. Road Kandallotown, MiD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or help failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** Gunshof Wound disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 XNo 3 Probably 4 Unknown Completed certificate has birector, page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No autopsy performed? 1X Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner?
1 XYes 2 No Be 26. Place of Death Check onl. one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 21:25 Subject shot hours after death. investigation 1 ☐ Yes 2 XNo 11/05 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide Kesidelle 2713 Tivuly Ave Baltimore, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Zalvinellal Al O.C.M.E. February 04, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 8 2005 Registrar

Description for instruction (Prot. Middle). Last) Republication A. LEVINE Discription for instruction, give already and currency a. Facility Name of Irred continuous, give already and currency Sinal Hospital Director Di	-0000)		For State	State of Mai	ryland / Dep	artmer	t of H	lealth a	and N	•	•	ible.	03692
ROSE A. Sealing Name of rout outstands, give sheet and number) Sinal Hospital Singuistand (rout outstands, give sheet and number) Sinal Hospital Singuistand (rout outstands, give sheet and number) Sinal Hospital Singuistand (rout outstands, give sheet and number) Sinal Hospital Singuistand (rout outstands, give sheet and number) Sinal Hospital Singuistand (rout outstands, give sheet and number) Sinal Hospital Singuistand (rout outstands, give sheet and number) Sinal Hospital Singuistand (rout outstands, give sheet and number) Sinal Hospital Singuistand (rout outstands, give sheet and number) Sinal Hospital Singuistand (rout outstands) Singuistand			Registrar			ertificat	e of i	Death				UU	
Since in Properties Figure 1997 19	Physicia	an					LEVI	NIT.		Month	Day		3. Time of Death
Sinal Hospital Sinal Hospital Sinal Hospital Sinal Hospital Online Control Office Control Of						4h Cin			of Dogsth	Februar			14:20 P
Second Source Number of 11-01-1668 Silver Number of 11-01-1668 Silver Number of 11-01-1668 Silver Number of 11-01-1668 Silver Number of 11-01-1668 Silver Number of 11-01-1668 Silver Number of 11-01-1668 Silver Number of 11-01-1668 Silver Number of 11-01-1668 Silver Number of 11-01-1668 Silver Number of 11-01-1668 Silver Number of 11-01-1668 Silver Number of 11-01-1668 Silver Number of 11-01-1668 Silver Number of 11-01-1668 Silver Si	Examine	er	_	treet and number)					of Death		4c. Count	-	
USAL Flatentine Debender 10x Care 10x Ca				7 Age	(In vrs. last hirthda				24 Hrs.	8 Date of Birth		· · · · · ·	
The State of December Total Country Total Index Total Country Total										0472671	914	Col	untry) MA
Elementary/Secondary (0-12) College (1-for 5-) SALESPERSON GARMENT			Usual Residence of Decedent					1	1				
Elementary/Secondary (0-12) College (1-for 5-) SALESPERSON GARMENT	ylan		10a. State 10b. County		10c. City, Town or	Location							10d. Inside City Limits
Elementary/Secondary (0-12) College (1-for 5-) SALESPERSON GARMENT	a-f s	ctol	MD N/A		BALTIMO	RE							1 Yes 2 □ No
Elementary/Secondary (0-12) College (1-for 5-) SALESPERSON GARMENT	or 28	olre.	10e. Street and Number			10f. Zip	Code				-	What Co	untry?
Elementary/Secondary (0-12) College (1-for 5-) SALESPERSON GARMENT	23a	al	6221 WOODCREST AV	ENUE		21	.209				U.S.A.		
Elementary/Secondary (0-12) College (1-for 5-) SALESPERSON GARMENT	r des	Inel	11. Marital Status	Armed Forces?	1	Was Dece	dent of H	ispanic Ori in, Mexicar	igin? (Sp	ecify Yes or No- Rican, etc.)			
Elementary/Secondary (0-12) College (1-for 5-) SALESPERSON GARMENT	or the safe	УFL	.,	1 ☐ Yes 2 ♠ No If Yes, Give	•							141	
Elementary/Secondary (0-12) College (1-for 5-) SALESPERSON GARMENT	hours Line	Q D			10= D	to set 11							
Physician Medical Examinor Physician Medical Cause (Final disease or miles) Physician Medical Examinor Physicia	n 72	lete	(Specify only highest grade	completed)	16a. Dec	edent's Usu e kind of wo	ai Occupi ink done (se retire)	ation during mos	it of work	ring	16b. Kind of b	dusiness/I	ndustry
Physician Medical Examinor Physician Medical Cause (Final disease or miles) Physician Medical Examinor Physicia	withii ene.	ш		College (1-4or 5+	-)			,				GARI	MENT
Physician Medical Examinor Physician Medical Cause (Final disease or miles) Physician Medical Examinor Physicia	Hygin Hygin C							18. Mothe	er's Nam	e (First, Middle, N	laiden Suma		
Physician Medical Examinor Physician Medical Cause (Final disease or miles) Physician Medical Examinor Physicia	Id be ental ked of ic ev	o B	MORRIS			KEEZEF		FI	RANC	ES	WISEM	ΔN	
Physician Medical Examinor Physician Medical Cause (Final disease or miles) Physician Medical Examinor Physicia	shound M	-		oe, Print)	19b. Ma	iling Address	(Street	and Numb	er or Rur	al Route Number,			ip Code)
Physician Medical Examinor Physician Medical Cause (Final disease or miles) Physician Medical Examinor Physicia	Nd 2 alth a 27 ls 27 ls		ARLENE TELES / DA	JGHTER	62	21 WOO	DCRE	ST A	VENU	E BALTIM	ORE, M	D 212	209
Physician Medical Examinor Physician Medical Cause (Final disease or miles) Physician Medical Examinor Physicia	Item of He other				20b. Place of Dis	position (Na	ne of	(a)		Date 2	20c. Location	- City or 1	Town, State
Physician // Indecical Examiner Physician // Indecical Examiner	Page nent c nt: If iry or			emoval from State	1				02/0	4/2005	BALTIM	ORE.	M D
Physician // Indecical Examiner Physician // Indecical Examiner	mit. partm ports y inju		21. Signature of Funeral Service License	7 112							ON & B	ROS.	, INC.
Physician Medical Examiner Physician Medical Examiner Physician Medic	88188		Acoll M. a	Mer		8900 F	EIST	ERST	OWN !	ROAD - P	IKES∀I	LLE,	MD 21208
Physician Medical Examiner Physician Medical Examiner Physician Medic	J1780 1		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	cations that caused t	the death. Do not e	nter the mod	le of dyin	g, such as	cardiac	or respiratory arre	st,		Approximate Interval Between
Due to (or as a consequence of):	Physician		Immediate Cause (Final	West	1 7 -	. "							Onset and Death
Sequentially list conditions, its conditions,				Due to (or as a									
ODD TO STATE OF THE STATE OF TH			Sequentially list conditions										
ODD TO STATE OF THE STATE OF TH	p is	Iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):								
The completion of the comple	and -trans	каш	that initiated events	Due to for as a	consequence of\:								
Section Control Cont	e cia	E		Due to (or as a	consequence or):								
Section Sect	- W - W	dica					-						
Column C	Se as	/Me		3c. If ves. outcome o	of pregnancy						224 D	ato of doli	von.
Column C	atter tor u	clar	in the past 12 months?	1 ☐ Live birth 2	2 ☐ Fetal death 3			,					,
Attractive and particles of particles and pa		ıysi	1 ☐ Yes 2 Ma No 9 ☐ Unknown								i.		
24a. Was an autopsy performed? 1	that thed b	y Pt			t not resulting in the	underlying o	ause giv	en in Part I	l.	23e. Did tob	acco use cor	tribute to	the cause of death?
24a. Was an autopsy performed? 1	uid be	q p	Atherosclerotic Cardio	ruseular	Disease					1	s 201 No	3 ☐ Pro	babiy 4 Dunknown
autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 2 No 1 Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N	Should should	lete								24a. Was ar	24b.	Were au	topsy findings available
USYNO See Note: Second S	ne la has age 2	duc								perform	ned?	prior to c	ompletion of cause of
1 Inpatient 2 SER/Outpatient 3 DOA Survival All Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 2 Inpatient 2 SER/Outpatient 3 DOA Survival All Nursing Home 5 Residence 6 Other (Specify) 28d. Date of Injury (North, Day Year) 28d. Date of Injury (North, Day Year) 28d. Describe how injury occurred Residence 6 Other (Specify) 28d. Describe how injury occurred Residence 6 Other (Specify) 28d. Describe how injury occurred Residence 6 Other (Specify) 28d. Describe how injury occurred Residence 6 Other (Specify) 28d. Describe how injury occurred Residence 6 Other (Specify) 28d. Describe how injury occurred Residence 6 Other (Specify) 28d. Describe how injury occurred Residence 6 Other (Specify) 28d. Describe how injury occurred Residence 6 Other (Specify) 28d. Describe how injury occurred Residence 6 Other (Specify) 28d. Describe how injury occurred Residence 6 Other (Specify) 28d. Describe how injury occurred Residence 6 Other (Specify) 28d. Describe how injury occurred Residence 6 Other (Specify) 28d. Describe how injury occurred Residence 6 Other (Specify) 28d. Describe how injury occurred Residence 6 Other (Specify) 28d. Describe how injury occurred Residence 6 Other (Specify) 28d. Describe how injury occurred Residence 6 Other (Specify) 28d. Describe how injury occurred Residence 6 Other (Specify) 28d. Describe how injury occurred Residence 6 Other (Specify) 28d. Describe how injury occurred Residence 6 Other (Specify) 28d. Describe how injury occurred Residence Residence 6 Other (Specify) 28d. Describe how injury occurred Residence	In In In In In In In In In In In In In I	a	25. Was case referred to medical		· · · · · · · · · · · · · · · · · · ·			26 Place	e of Deat			1 LA Yes	2LI N0
The state of the s				ospital: 1 🗆 Inpatien	nt 2 🖼 ER/Outpat	ent 3 D	Oth	or.				her (Spec	afv)
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifying Physician: To the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	g Ph er thi			28a. Date of Injury	28b. Time	-						- ' '	//
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	ath. r: Afr	atlo	2 Accident investigation		198	101							
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	Visa view of the contractor by the by the contractor of the contra	tific		28e. Place of Injur	ry · At home, farm,	street, factor	y, office			28f. Location (Str.	eet and Num	ber or Ru	ral Route Number,
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	rs aft	Cer		street					ĺ	loss have	P. Kesvill	e, MO	NON MIL & NOU
Manufacture Marketting	lospi Thou uner		29a. Certifier 1 Certifying Physical Check only 2X Medical Examination	ician: To the best of	f my knowledge, de examination and/or	ath occurred	at the tin	ne, date ar	nd place,	and due to the ca	use(s) and m	anner as	stated.
Manufacture Marketting	the H the F the F	Nedi	Oney	and manner state	ed.	-							
OCME DISCHARGE THE CONTRACTOR OF THE CONTRACTOR	5 × 5 × 0	~	29b. Signature and title of certifier	1/ 1/ 1/		29	c. Licens	e number		25	d. Date signi	ed (Month	, Day, Year)
February 4, 2005	4		Pancete Dorch	hallim)			OCM	Ε		F	ebruar	y 4,	2005
30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)	10		30. Name and address of person who co	mpleted cause of de			O		ъ -				
Pamela E. Goviffull, M.D. 111 Penn Street Baltimore, Maryland 21201	W		31 Date filed (Month Day Year)	WIII, MI.J.		TT Lei	ın St	reet	Ba⊥	timore,	Maryla	nd 21	1201
State						P. W.							
Registrar FER 0 8 2005 DHMH 17 Rev 1/2001	* .	1,0	FEB 0 8 200	Diegen.	. 15. A	OCALL)							
ORIGINAL					ORIGIN	IAL							

HARRY MCGUIRE 05-01009 RKD

			For State Registrar	State	of Marylar		artment of rtificate of		nd Mental		2005	03693
	Physici	an	1. Decedent's Name (First, Middle	, Last)					2. Date		y Year	3. Time of Death
	/Medic	al	HARRY	MCGUIRE						UARY 5	2005	10:50A. M
	Examin	er	4a. Facility Name (If not institution	, give street and no	imber)		4b. City, Town,		Death	40	:. County of Deatl	h
	Funeral		SINAI HOSPITAL 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	BALTIM If Under 1 Year	If Under 2	4 Hrs. 8. Date	of Birth		nplace (State or Foreign
	Director		217-20-1232	₩ 2 □ F	7		Months Days	Hours		of Birth h, Day, Year, 4 192		untry) RYLAND
	p ,		Usual Residence of Decedent 10a. State 10b. County		100 Ci	ty, Town or Lo						10d. Inside City Limits
	Aaryla Fahov	ō			100.01							1 ⊠Yes 2 □ No
	28a-	Director	MARYLAND N/A 10e. Street and Number			BALT	IMORE 10f, Zip Code			10g. Ci	tizen of What Co	untry?
	3a or		5328 LIBERTY	HETCHTS A	VENUE		212	0.7			S.A.	,
	death	Funeral	11. Marital Status		edent Ever in U	l.S. 13.	Was Decedent of If Yes, specify Cul		in? (Specify Yes		14. Race - Ame Black, White	
98	or Its	Fu	1 Never Married XX Marr		2 1 No	1	1 ☐ Yes XX No		r derio r noari, etc	,	Specify:	a, etc.
21215-0036	72 hours after death with the Maryland "natural", or Itams 23a or 28a-f ahow dical Exit fact must be redified at	ed by	3 ☐ Widowed 4 ☐ Divorced		Dates:	162 Dece	dent's Usual Occu	ention		105 1	BLA	ACK
15	_ x	Completed	(Specify only highes	st grade completed		(Give	kind of work done DO NOT use retire	during most	of working	100. F	(ind of Business/	industry
212	d within giene. r then "	mo	Elementary/Secondary (0-12) 12th grade	College	(1-4or 5+)	BUIL	DING ENG	INEER		STA	TE MED I	EXAMINER
nd	be filed within tal Hygiene. d other then avant, the Me	Be C	17. Father's Name (First, Middle,	Last)				18. Mother	's Name (First, M	iddle, Maidei	Sumame)	
ylai		To E	JOHN MCGUIRE					ETH:	EL HOLME	S		
Maryland	and and ls m		19a. Informant's Name/Relations			19b. Maili	ng Address (Stree	t and Number	r or Rural Route N	umber, City	or Town, State, Z	tip Code)
	s 1 and 2 if Health itam 27 othar tr		EUNICE V. MCGU 20a. Method of Disposition	IRE/Wife	20h		8 Libert	y Heig	hts Ave.		imore, Nocation - City or	Ad., 21207
סַר	of of		XX Burial 2 Cremation		State	cemetery, cre	matory or other pla		2-14-05			
altimore,	그 든 원 글		'4 □ Donation 5 □ Other (S		GA		FOREST 2. Name and Addr			OWIN	IGS MILLI	S, MARYLAND
Ba	Depa Impo any ir	0 10	154/5-			W	ILLIAM C	BROWN	COMMUNI	TY FUN	ERAL HO	ME P.A.
	*		3a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea					ory arrest,		Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition	11	nous here	Siver	Altre	1251.60	rapic 1	Carrior	mader	Onset and Death
	/Medical		resulting in death)	a. Due t	(or as a consec	quence of):	1 101					00000
	Examiner	_	Sequentially list conditions,	b	,							
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quence of):						
	s be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c	o (or as a consec	quence of):						
8760,	death certificate be executed e attending physician and of for use as the burial-transit			d								
89	tificate ig phys as the	ledical										
Вох	leath certifica attending ph ifor use as th	an/N	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn birth 2 ☐ Feta		⊒Ectopic pregnan	cv			23d. Date of deli	
O. E	ne dea the att hed fo	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□Unk	nant at time of one		Other (specify)			- 1	Month	Day Year
P.	a o	Phy	Part If. Other significant condition	OBS contributing to	death but not re	sulting in the I	inderlying cause o	Iven in Part I	230	Did tobacco	use contribute to	the cause of death?
Records,	signed to be det	d by		one continue and to		outing in the	andonying outdoorg	TOTAL COLL	400.	1 ☐ Yes 2		obably 4 Unknown
Sor	w requir been si should	lete			-				242	Was an	24h Were au	topsy findings available
Re		Completed								autopsy performed?	prior to death?	completion of cause of
Vital		0	25. Was case referred to medica	ı				26. Place	of Death (Check		0 1 ☐ Yes	2□ No
Ž	Physician: this certific ral director.	To B	examiner? 1X Yes 2 □ No	Hospital: 1	Inpatient 25	ER/Outpatie	nt 3 DOA	thon	sing Home 5		6 ☐Other (Spec	cify)
n of			27. Manner of Death 1X Natural 5 ☐ Pendir		of fnjury nth, Day Year)	28b. Time o	of 28c. Inju	ury at ork?	28d. Desc	ribe how inju	ary occurred	
sio	Attending r death. sctor: After by the fune	catl	2 Accident investi 3 Suicide 6 Could	gation not be				Yes 2□N				
Division	l or At after d Diract I in by	Certification:	4 Homicide determ	ined 286. Plac	ce of fnjury - At t ding, etc. <i>(Spe</i> c		reet, factory, office	•		ion (Street a or Town, Stat		ral Route Number,
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 ☐ Certifyir	ng Physician: To t	nerbest of my kn	owledge des	th occurred at the	time date and	place and due to	the cause/s	and manner as	stated
	e Hos 24 h a Fur letely	edical	(Check only and one)	Exeminer. On the	basis of examin nner stated.	ation and/or i	nvestigation, in my	opinion, deat	h occurred at the	time, date an	d place, and due	to the cause(s)
	To the within 2 To tha complet	Me	29b. Signature and title of certifie	1/4/				nse number		29d. Da	ate signed (Monti	n, Day, Year)
				//hm/	1		0	CME		FEBR	UARY 8,2	2005
	6	ļ	30. Name and address of person DAVID R. FOWLER	who completed ca	use of death (Ite	m 23a) (Type	111 Pe	nn Str	eet Balt	imore,	Marylar	nd 21201
*	St Regist	ate rar	31. Date filed (Month Day, Year,	8 2005	Polistrar's Sign	ature .	breeks.					

			1 - For State Registrar	State of M	laryland / Depa	artment of He rtificate of D		_	ene 005	03694
	Physici /Medic		Decedent's Name (First, Middle, L ANNETTE	ast) MISSOURI				2. Date of Death Month February	Day Year	3. Time of Death 10:50 p ^M
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number	r)	4b. City, Town, or L	ocation of Death		4c. County of Death	
	Funeral Director		220-36-3093		age (In yrs. last birthday) 65 Yrs.	BALTIMOI If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	'ear) Cou	place (State or Foreign intry) RYLAND
e, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hyglene. Important: If Itam 27 Is marked other than "natural; or Items 23e or 28e-f show any injury or other traumatic avant, the Myclical Engine and must be multibed at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MARYLAND 10e. Street and Number 4436 RASPE AVE 11. Marital Status 1 Never Married 2 Married 3 Widowed 15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12th grade 17. Father's Name (First, Middle, Last RUFUS CALWRIE 19a. Informant's Name/Relationship Robin A. Missour	12. Was Deceder Armed Forces 1 Tyes 2 2 If Yes, Give Year or Dates Education rade completed) College (1-4o	16a. Dece (Give life. CLA	DRE 10f. Zip Code 2120 Was Decedent of Hisp If Yes, specify Cuban, 1 Yes 2 No dent's Usual Occupati kind of work done du DO NOT use retired) IM ADJUSTE: 1 ng Address (Street an Raspe Ave	nanic Origin? (Spe Mexican, Puerto F Specify: on ring most of workin R 8. Mother's Name MARY F d Number or Rural	city Yes or No-Rican, etc.) 16 (First, Middle, Mathematical Route Number, Conce, Md.	City or Town, State, Zi	ican Indian, , etc. CK Industry
Baltimore,	permit. Pages 1 Department of H Important: If Ital any injury or ott		20a. Method of Disposition 12 Burial 2 □ Cremation 3 14 □ Donation 5 □ Other (Spec 21. Signature of Fungrat Service Lic 23a. Part 1. Enter the disease, or co	ensee	Mt. Calva	matory or other place) ary Cemete: 2. Name and Address ILLIAM C B1 206 W NORTE	ry 02-5- of Facility ROWN COMM H AVENUE	-05 GI	JNERAL HOM	, MARYLAND
8760, ~	Physician /Medical Examiner physician and physician and stree purial-transit	edical Examiner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	line.	ICER	MEDAZ	হ্যেকা(,	Approximate Interval Between Onset and Death
P.O. Box 6	The law requires that the death certiticate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	rery Day Year
	w requires that been signed t should be det	by	Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause given	in Part I.		cco use contribute to	
al Records,		Completed						24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of 2 No
ion of Vital	or Attanding Physician: The titer death. Diractor: After this certificate hi in by the funeral director, page	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 27. Manner of Death 15. Natural 5 Pending investigati	Hospital: Hospital: 28a. Date of In (Month, E	jury 28b. Time o	other: 1 3 DOA 28c. Injury a Work?	at 2		ce 6 Other (Speci	ify)
Division	To the Hospital or Attant within 24 hours after deatl To the Funaral Director: completely tilled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	ed 28e. Place of I	njury - At home, farm, st. etc. <i>(Specify)</i>	reet, factory, office	2	8f. Location (Stre City or Town.	et and Number or Rui State)	al Route Number,
	To the Hospital or within 24 hours after To the Funaral Dit completely tilled in	edical	29a. Certifier 1 € Certifying I (Check only one) 2 ☐ Medical Ex-	hysician: To the bes aminer: On the basis and manner	st of my knowledge, deat of examination and/or in stated.	h occurred at the time, vestigation, in my opin	, date and place, a nion, death occurre	nd due to the cau d at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
)	To the within 2 To the complete	M	29b. Signature and title of certifier Prush Att	15 MD		29c. License r			Date signed (Month,	
	A		30. Name and address of person wh	o completed cause of	death (Item 23a) (Type,	Print) PLACE	BADTI	more	21252	•
	Sta Regist		31. Date filed (Month, Day, Year) FEB 0 8	2005	Strar's Signature	booles				

			For State Registrar	State of M	laryland / D	epa Cer	rtment of He tificate of E	ealth a Death	and M		€)1 €) g. No.	05	0369	5
			1. Decedent's Name (First, Middle, Last)							2. Date of Death Month	Day	Vass	3. Time of	Death
	Physici: /Medic		Georgia G	arner Me	yersburg]	February		2005	7:30	\mathbf{p}^{M}
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or I	Location o	f Death		4c. C	ounty of Deat	1 2 2	
			Mariner Healthcare	at Circ	le Manor	ŀ	Kensingt	on				Monts	gomery	
	Funeral		5. Social Security Number 6. Sex		ge (In yrs. last birtl	hday)	If Under 1 Year Months Days	If Under :	24 Hrs. Min.	8. Date of Birth (Month, Day,	Voar)		hplace (State or untry)	Foreign
	Director		577-56-1594 ¹	M 2CXF	65 Y	rs.	WOITING Days	riours		ЛИL 3, 1	939		entucky	
	p ,		Usual Residence of Decedent 10a. State 10b. County		10. 05. 7									
	anyla shov	_			10c. City, Town								10d. Inside Cit	
	Be-f	ctc	Maryland Montgome	ry	S:	ilv	er Spring)						~ [N40
	vith ti	Director	10e. Street and Number				10f. Zip Code	200	00		-	n of What Co	untry?	
	within 72 hours after death with the Maryland ene. Than "neturel", or items 23a or 28a-f show ha Mardical Examinar mast be motified at	Funerai	1113 Devere Drive	- 111				209			USA			
	er de item	nue		2. Was Deceden Armed Forces	?	13. W	as Decedent of His Yes, specify Cuban	panic Orig , Mexican	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	14	. Race - Ame Black, White		
36	s aft	by F	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 2 🔯 If Yes, Give Year or Dates	-	1	☐ Yes 2∏ No	Specify:			s	pecify: [J]	nite	
Ş	hour turel		15. Decedent's Educ			Dood	ent's Usual Occupa	tion		1.4	Ch Vine			
<u>.</u>	in 72	Completed	(Specify only highest grade	completed)		(Give k	and of work done du O NOT use retired)	ırina most	of workin	ng ''	DD. KIIIC	of Business/	industry	
7	with iene.	mo.	Elementary/Secondary (0-12)	College (1-4or		Hom	emaker				Otar	1 Home		
0	be filed within 72 hours after death with the Marylan hat Hygiene. Id other than "naturel", or liems 23a or 28e-1 show or other than "naturel", or liems 23a or 28e-1 show event. The Maryland Examination at the maryland at	0	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle, M.			····	
an	ld be ental ked c	To B	Harold Myer Ga	rner				Ka	thloc	en Louis	a Wi	1con		
Baltimore, Maryland 21215-0036	s 1 and 2 should be f Health and Mental item 27 Is marked o other treumetic ev	-	19a. Informant's Name/Relationship (Ty)		19b.	Mailine	Address (Street a						Zip Code)	
S	nd 2 lith ai 27 is r treu		Richard H. Meyersb	urg/Hush	and 1	113	Devere D	rive	Sils	zor Stri	000	MD 206	C 2	
ē,	Hea Hea Heam other		20a. Method of Disposition		20b. Place of	Dispos	ition (Name of					tion - City or		
J10	y or		1 ☐ Burial 2 🕅 Cremation 3 ☐ R. `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	9 '		atory`or other place	· I	2/5/0).	Ral t	imore,	MT	
	artme orten injur	14		10/10	metro		natory, I					лиоте,	MD	
Ba	permit. Pages 1 and 2 Department of Health s Importent: If item 27 is any injury or other tre		21. Signature of Funeral Service Licenses Edward A. Greg	orchik		C	Name and Address remation	Soci	éty c	of MD, I	nc.	MD 01	000	
			23a. Part1. Enter the disease, or compli-	cations that cause	ed the death. Do n		99 Freder					MD ZI	228 Approximate	
	VANABLES .		shock, or heart failure. List only on Immediate Cause (Final							,			Interval Betw Onset and D	reen leath
	Pnysician /Medical		disease or condition resulting in death)		st Canc			- 6 -						
	Examiner			Due to (or a	s a consequence o	и):								
		e.	Sequentially list conditions, if any, leading to immediate		s a consequence o	of):			-					
	d I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
ć	execting and and ial-tra	Exa	resulting in death) Last	Due to (or a	s a consequence o	of):						-		
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai												
68	ificat g phy as th	0												
Вох	death certifica attending ph d for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcom		• □					23	d. Date of del	ivery	
m	death	icia	in the past 12 months? 1 □ Yes 2 ☑ No	4□Pregnant	2 Fetal death at time of death		Ectopic pregnancy Other (specify)					Month	Day Y	ear
0	that the ded by the detached	hys	9 Unknown	9□ Unknown										
٦.	es tha igned be det	by P	Part II. Other significant conditions con	tributing to death	but not resulting in	the un	derlying cause give	n in Part I.		23e. Did toba	icco use	contribute to	the cause of de	ath?
rg	w require been sig should b									1 ☐ Yes	2 🗹	No 3□Pr	obably 4 🗆 U	nknown
Vital Records,	aw requas been 2 shoul	ompleted								24a. Was an		24b. Were au	topsy findings a	vailable
Re	The la ate ha page	шo								autopsy	ed?	death?	completion of ca 2 □ No	use of
tal		e C	25. Was case referred to medical		·			26. Place	of Death	(Check only one		1 1 102	2U NO	
	Physicien: this certific ral director,	0.0	examiner? 1 ☐ Yes 2 ☑ No	ospital:	tient 2 ER/Out	patient	Otho	-		ne 5 Residen		Other (Spec	cify)	
o l		n: T	27. Manner of Death	28a. Date of In		ime of	28c. Injury Work			8d. Describe hov			,7	
jo	Attending I r death. ector: After by the funer	atio	1 ▼Natural 5 ☐ Pending 2 ☐ Accident investigation	(NOTAL), D	uy 1021) 11	ijui y		es 2 🗆 l	No					
Division	I or Attendii after death. Director: A d in by the fu	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of I	njury - At home, far	m, stre	et, factory, office		2	81. Location (Stre		Number or Ru	ıral Route Numb	oer,
	s afte	Certification;	T I TOTAL CONTROL OF THE PARTY	busiding, t	stc. (Specify)					Only or rown,	Siale)			
	ospi hour uner		29a. Certifier 1 ✓ Certifying Phys (Check only 2 ☐ Medical Examin	sician: To the bes	it of my knowledge,	, death	occurred at the time	e, date an	d place, a	ind due to the cau	ise(s) a	nd manner as	stated.	
	To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by th	ledicai	(Check only 2 Medical Examination)	and manner	stated.	wor inv	esugation, in my op	iiion, dea	un occurre	ru at trie time, dat	e and p	ace, and due	to the cause(s)	
	with To t	Σ	29b. Signature and title of certifier				29c. License	number		29	d. Date	signed (Monti	h, Day, Year)	
	1		In	en P	Zer, in	D	D 00	25	7/2	4	**	215	105	
	14		30. Name and address of person who co	mpleted cause of	death (Item 23a) (Type, F	Print)	_	1		E O STITE	^	,	
_	,		loung Bag.	13219	xecutive	Bly	d c11.	Vell	MALITOR	W. W	1)	2087	1	
	Sta		31. Date filed (Month, Day, Year) FEB 0 8 20		ar's Signature		>)				
	Registi	ar	FEB 0 8 50	U5	less. H	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepe Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Charles William Meade 3 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Franklin Souare Hospital Rosedale f Under 1 Year | If Under 24 Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 1 XM 2 ☐ F **Funeral** Days Min 577-54-2415 64 Director Virginia Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 ☐XNo Directo Marvland | Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 12 Kilmory Court itams 23a 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 XNever Married 2 ☐ Married 5 Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician s 1 and 2 should be filed w f Health and Mental Hygier itam 27 is marked othar th other traumatic event, the Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Ollie Meade Agnes Lorraine Hess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other train Shanon M. Meade/Daughter 12 Kilmory Court Baltimore, MD 21236 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) 2/5/05 Metro Crematory, Inc. Baltimore, MD 21. Signat & of Funeral Service Ocensee

Edward A Cregorchik ²² Name and Address of Facility Cremation Society of MD, Inc 299 Frederick Road Baltimore 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Se resulting in death) /Medical Examiner mmunocompromised Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy 1□ Yes Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 2 X No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation s after dec. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours at To the Funeral E completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To tha 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Res 0000 30. Name and address of person who comple ad a use of death (Item 23a) (Type, Print) 9000 Franklin Square Drive, Baltimore, MD 21237 2. Republicans Signature

DHMH 17 Rev 1/2001

Registrar

Dr. Katharina

			For State Registrar	State of Mary		artment of		and Me		iene	0.5	0369	7
	0		Decedent's Name (First, Middle, Last)					2.	Date of Deat	h	V	3. Time of Dea	th
	Physici /Medic		Ruth Gert	rude McMaho	on			F	EB 8,	2005	Year	4:45a	М
	Examin		4a. Facility Name (If not institution, give				n, or Location of			4c. County			
			Manor Care Silver	Spring		Silv	er Spr	ing		Mo	ntgom	ery	
	Funeral		5. Social Security Number 6. Sex		92 Yrs.	If Under 1 Ye Months Da		24 Hrs. 8. Min.	Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or For	eign
	Director		080-14-5111	1W 2AL	92 Yrs.			M	AR 20,	1912_	New Y	York	
	pug *	-	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation					1	0d. Inside City Lir	mits
	Aanyl f sho	ō	Maryland Montgor	narv		Silvor	Spring					1 ☐ Yes 2X	
	28a-	ec.	10e. Street and Number	ncry		10f. Zip Cod		·	1	0g. Citizen of	What Cour	ntry?	
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Examinar cost be notified at	Funeral Director	3701 Internationa	al Drive Ap	t. #316		20906				USA	•	
	ms 2	era		12. Was Decedent Eve		Was Decedent of Yes, specify 0	of Hispanic Ori	gin? (Specif	y Yes or No-		ce - Americ		_
က္	or Ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		lfYes,specifyC 1□Yes 22XI		n, Puerto Rio	an, etc.)		ck, White,		
9	ral', c	ρ	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 LIYes 2L∠XI	No Specify:			Specit	y: Whi	LLE	
5-0	72 h	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual Oc kind of work do	one during mos	t of working		16b. Kind of B	usiness/In	dustry	
21	within ene. than "	npl	Elementary/Secondary (0-12)	College (1-4or 5+)		oo not use re emaker	tired)			D			
2	led w tygien her ti		17. Father's Name (First, Middle, Last)		ПОШЕ	emaker	10 Moths	ode Name //	iest Middle	Domest			
anc	htal H	Be	John Erkman						Meyer	Maiuen Sumai	ne)		
Z Z	should nd Men n marke umatic	10	19a. Informant's Name/Relationship (Ty	ne Print)	10h Maili	na Address (Str				City or Town	State Zin	Code) 2090	
Maryland 21215-0036	01 00 00 00		Faith B. Walker/n									Spring, I	-
d)	Health Health tem 27		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	f	Dat		20c. Location			עני.
no I	ages ant of it: If II		1 ☐ Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Metro Cre	matory or other ematory	, Inc.	2/9/0	5	Ba1	timo	ce, MD	
Baltimore,	permit. Pages: Department of H Important: If Ite any Injury or ot		21. Signature of Funeral Service Licens			Name and Action						,	
ä	Depar Impo any Ir		> Sumpl	MaDanald		299 Fred						າງຊ	
			23a. Part1. Enter the disease, or complete or head failure.	ications that ceused the							W 212	Approximate Interval Between	
	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	C C	nagnti	Ve. h	part	Fai	1110			Onset and Death	5
1	/Medical		resulting in death)	Due to (or as a co	nousti	IN		1001	1010			TEATS	
	Examiner		Sequentially list conditions	0									
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):								
	ecute and -trans	Examiner	that initiated events resulting in death) Last	Due to (or as a co	ancoguence of):								
8760,	be executed sician and burial-transit			Due 10 (01 as a 01	orisequence or,								
87	ate hy:	Physician/Medical		d									
9 X	n certific anding pl use as t	/Me	IF FEMALE:	23c. If yes, outcome of p	pregnancy					23d D:	ate of delive	arv	
Вох	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at tim		∃Ectopic pregna ∃ Other (s <i>pecif</i> y					onth	Day Year	
o.	to the de tached	ıysi	1 Yes 2 No 9 Unknown	9□ Unknown									
D .	res that igned to be deta	by P	Part II. Other significent conditions co	ntributing to death but n	ot resulting in the u	nderlying cause	e given in Part I	l.	23e. Did to	pacco use con	tribute to t	ne cause of death	?
Vital Records,	- w D	ed t	COPD						1 🗆 Y	es 2 🗆 No	3 Prob	ably 4 Unkn	own
000	law requasi been 2 shoul	Completed	CHRONIC R	ENAL IN	USUFFIC	MENCY	1		24a. Was a		Were auto	psy findings avail	able
Ä	The laste has page	EO							perfori	ned? 2 X No	death?		01
ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place	e of Death (Check only or	1			
of V	d is	10	1 □ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie			ursing Home	5 🗍 Reside	ence 6 🗆 Ot	her (Specit	(y)	
		on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time o		Injury at Work?		d. Describe h	ow injury occu	rred		
Sio	eath or:	cati	2 Accident investigation 3 Suicide 6 Could not be		111111111111111111111111111111111111111		1 Yes 2				h O	1.D	
Division	or Attendated after death Director:	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (.	- At nome, farm, st Specify)	reet, factory, off	lice	28	City or Town		oer or Hura	al Route Number,	
	pital ours a leral l		29a. Certifier 1 Certifying Phy	sician: To the best of n	ny knowledge deat	h occurred at th	ne time date ar	nd place, an	d due to the c	ause(s) and m	anner as s	tated	
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edicai	(Check only 2 Medical Exemione)	ner: On the basis of ex and manner stated	amination and/or in	ivestigation, in r	my opinion, dea	ath occurred	at the time, d	ate and place	and due to	the cause(s)	
	ro th within ro th compl	Me	29b. Signature and title of certifier	0			cense number		2	9d. Date sign			
	1		· Mi	10de	-, MD	Ţ	0567	97		Feb.	8,	2005	1
	, 15		30. Name and address of person who c	ompleted cause of deat	h (Item 23a) (Type,	Print)							
	10		Lalitha Tadikond	a, M.D. 139	952 Balti	more Av	enue I	Laurel	, MD 2	0707			
	St. Regist	ate	31. Date filed (Month, Day, Year) FEB 0 8 20	32. Palakar's	Signature	1							
	negist	rai	1 20 0 0 20	JUJ REMEM	J J 4	2000 P. 13.							

Meditt, melvin

			Please T	ype or Print in Black Indelible Ink.	Ensure All C	opies Are	Legible.	
			For State Registrar	State of Maryland / Department of He Certificate of D		ntal Hygiene	บบอ	03698
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last) 4a. Façility Name (If not institution, give s 5. Social Security Number 6. Sex	ATMERCY BAIT	Location of Death The RE If Under 24 Hrs. 8,	Date of Death Month Day	y Year 2005 County of Death	3. Time of Death 17:50 A M place (State or Foreign
*	Director	4	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	(1),	Ay 24, 19	2/11.(AROLINA
	the Maryla 28a-f shor	Director	10e. Street and Number	BAHMORE	-	10.00		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	eath with	Funerai Dir	1405 N. DECK	ER STREET 2121 2. Was Decedent Eyer in U.S. 13. Was Decedent of His	3		tizen of What Cou	4
5-0036	72 hours after death with the Maryland natural', or items 23a or 28a-f show diteal Examinar must be notilied at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eyer in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 13. Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ▼ No	Specify:	an, etc.)	Black, White,	
21	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 16a. Decedent's Usual Occupat (Give kind of work done du life. DO NOT use retired)	uring most of working	16b. K	ind of Business/tr	idustry
land 21	2 should be filed within and Mental Hygiene. Is marked other than sumatic avent.	Be	17. Father's Name (First, Middle, Last)	1.7	18. Mother's Name (Fi	rst, Middle, Maiden	Sumame)	Kaydon
Maryla		욘	19a. Informant', ame/Relationship (Ty	RRITT 19b. Mailing Address (Street ar 19b. Mailing Address (Street ar	Number or Rural Ro	RALL		o Code) MJ 21213
altimore,	9 = 5		20a. Method of Disposition 1	20b. Place of Disposition (Name of	"PL 2/11	20c. Lo	more of the pocation - City or T	own, State
Baltin	permit. Pa Departmer Important: any injury once.		21. Signature of Funeral Service License	22. Name and Address	Jon. Jon	55, JR 1	FunER to, md	AL SUCPA 21213
68760,	eath certificate be executed attending physician and increase as the burial-transit	lical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infilated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	, such as cardiac or u	spiratory arrest,		Approximate Interval Between Onset and Death
.O. Box	The law requires that the death certificate be the law seem signed by the attending physicial agge 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1			23d. Date of deliv Month	ery Day Year
rds, P.	w requires that been signed t should be deta	by	Part II. Other significant conditions cor	tributing to death but not resulting in the underlying cause giver	n in Part I.	\ <u>/</u>		the cause of death?
al Records,		e Completed	Of the case of an district			24a. Was an autopsy performed 1 Yes 2 No	death?	opsy findings available empletion of cause of
ion of Vital	ing Phy n. After this funeral o	To B	27. Manner of Death 1	ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?	4 Nursing Home		6 Nother (Specific ry occurred	W MSLICE
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (Street an City or Town, State	nd Number or Run a)	al Route Number,
	To the Hospital within 24 hours and the Funeral I completely filled	Medical	29a. Certifier 12 Certifying Try. (Check only 2 Medical Examinone)	ician: To the best of my knowledge, death occurred at the time ler: On the basis of examination and/or investigation, in my opi and manner states	e, date and place, and inion, death occurred a	due to the cause(s) It the time, date and	and manner as s d place, and due t	nated. o the cause(s)
	To t To t	Σ	29b. Signature and title of certifier Museum Manuel	achien my	1930	Eel Pel	te signed (Month,	7, 2005
	7		MARVIN J. FELDY	mpleted cause of death (Item 23a) (Type, Print) MAN 301 ST PAUL PLACE ST	TE407(T)	BALTIMI	DRE MO	21202
	Sta Registi		31. Date filed (Month, Day, Year) FEB 0 8 20	32. Bigistrar's Signature				

DHMH 17 Rev 1/2001

		•	1- State of Maryland / State of Maryland / Per Verb., G8	Depa 8 40 e (rtment of Health Cale of be	alth and M Bath	ental Hygi	ene 005	03699
	Physicia	20	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
	/Medic		Margo Capra McLaughlin				Jan.	23, 200	5 9:00 a M
4	Examin	er	4a. Facility Name (If not institution, give street and number) 781 Creek View Road	ļ	4b. City, Town, or Lo Severna			4c. County of De	ath Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last I	birthday)	If Under 1 Year If	f Under 24 Hrs.	8. Date of Birth		irthplace (State or Foreign Country)
п	Director	,	068-34-0160 1□M 2IXF 59	Yrs.	Months Days	Hours Min.	(Month, Day, Apr. 11		NY NY
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Lor	cation				10d. Inside City Limits
	Mary a-f sh	tor	MD Anne Arundel		Severna	Park			1 ☐ Yes 2 ☑ No
	or 284	Olrec	10e. Street and Number		10f. Zip Code		10	g. Citizen of What (Country?
	s 23a	ral	781 Creek View Road			21146		USA	
Maryland 21215-0036	d within 72 hours after death with the Maryland piene. rr than "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married If Yes, Give Year or Dates:		Vas Decedent of Hispa Yes, specify Cuban, I ☐ Yes 2【 No S	anic Origin? (Spe Mexican, Puerto (Specify:	icity Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	
5-0	natur	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	ent's Usual Occupatio	on ing most of working	ng 1	6b. Kind of Busines	s/Industry
121	within ene. than *	дшс	Elementary/Secondary (0-12) College (1-4or 5+)		oo <i>not</i> use retired) ter Softwa	re Analy	/st	Hunter G	roup
d 2	n the	Be Co	17. Father's Name (First, Middle, Last)	L			(First, Middle, M		
ylar		ToE	Aldo Capra			Margaret			
Mar	12 sho h and 7 is mu traum		19a. Informant's Name/Relationship (<i>Type, Print</i>) Clyde McLaughlin		g Address (Street and Creek Vie				
	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		20a. Method of Disposition 20b. Place	of Dispos	sition (Name of			Oc. Location - City of	
OW	Pages nent of int: if i		I Dunai Zauciemation 3 Daemovaritom State I		rematory or other place)	Jan.	25, 2005	Baltimore	, MD
Baltimore,	permit. Pages. Department of h important: if ite any injury or of		21. Signature of Fineral Service Licensee	3 4	Name and Address of arranco & 95 Gov. Ri			rna Park rna Park,	Funeral Home MD 21146
г			23a Part1. Establishe disease, or complication that caused the death. D shock or heart fathere. List only one cause on each line.						Approximate Interval Between Onset and Death
	Pnysician / /Medical		Immediate Cause (Final disease or condition resulting in death)		arcin	some			Chiest and Boam
	Examiner		Due to (or as a consequence	2 0 01):					
	p ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ce of):					
	ecuted and -transit	Examin	Cause (Disease or infjury that initiated events c	ac of):					
68760,	ficate be executed g physician and is the burial-transit		Bus to for as a consequence	<i>26</i> OI).					
687		edical	d.						
O. Box	The law requires that the death certif tie has been signed by the ettending bage 2 should be detached for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death	ath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
٠, ص	es that igned by be deta	by Ph	Part II. Other significant conditions contributing to death but not resulting	g in the ur	iderlying cause given i	in Part I.	23e. Did toba	acco usa contribute	to the cause of death?
ord	w require been sig should b						1 🗆 Yes	2 No 3 1	Probably 4 Unknown
al Records,		Completed					24a. Was an autopsy perform	prior to	
Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes	Outpatien	Othor		(Check only one	nce 6 Other (Sp	ecity)
Jo L				b. Time of Injury	28c. Injury at Work?		28d. Describe hov		вспу)
siol	tendir leath. tor: Al the fu	catic	2 Accident investigation		M 1 Yes	s 2 No			
Division	or Attendation of the or Attendation of the ortor:	Certification:	4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the pest of my knowled 2 Medicel Exeminer On the best of examination and mapner stated.	dge, death and/or inv	occurred at the time, restigation, in my opini	date and place, a ion, death occurre	and due to the cau ed at the time, dat	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License n	umber	29	d. Date signed (Mor	nth, Day, Year)
	6		1 Am Do		Hoos	1843		11240	25
	30		30. Name and address of person who completed cause of death (Item 23:	a) (Type, J	Print) C	7-		1 1	ld mo 2012
1	Sta	te.	31. Date filed (Month, Day, Year) 2. Registrar's Signature	7_	1 cuins	a tan	run ke	ed Hun	61018 am by
	Registr		FEB 0 8 2005 Kendra &	Spare	W				

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Maries

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Amend Item 10b-c per fh G840 2-9-05 tas Department of Health and Mental Hygienes Registrar AMEND ITEM #26 PER VERB C 840 2/08/05 JH Reg. No. Decadent's Name (First. Middle, Last)

2. Date of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Hleda /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Baldwin 4b_City, Town, or Location of Death Examiner 2101 If Unde Date of Birth 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 M 2 Hours Director Yrs. Harylan Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 28e-f show Baltimore Timonium 10d. Inside City Limit other traumatic event, the Medical Exercitive must be notified at 1 Yes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Items 23e Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Eve Armed Forces? in U.S. 14. Race - American Indian. Black, White, etc. Yes 2 TYes, Give 2 **N**o 2 Married 1 Never Married Baltimore, Maryland 21215-0036 "natural', or 1 ☐ Yes 2 ☑ No Specify: Completed by 3 Widowed 4 Woivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame Be 2 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7-E/d 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite eny injury or ot 10 = 1 Burial 2 □ Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Sign and of Funeral Service Licensee pnce M01220 YORK mD 2 1093 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Non-Imall Cell Metastan 6 Months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial- ransit certificate be executed Due to (or as a consequence of): 14Q, (C€, 26, of Vital Records, P.O. Box 68760 nding physician Physician/Medical the as esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery atten for u 3 DEctopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to condeath? this certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only he idence 6 X Other (Specify SON'S Hospital: Other: 2 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 DOA 4 Nursing Home in by the funeral 27. Manner of ath 28a. Date of Injury (Month, Day Year) 28b. Time of Residence 28c. Injury at Work? 28d. Describe how injury occurred Certification: Alter Division Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and itle of certife ncologi 29c. License number 29d. Date signed (Month, Day, Year) 5-02-07-05 D0056919 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) egistrar's Signature State

Registrar

FEB 08

2005

			For State		Department of Health a	nd Mental Hygie	ene 2005 n370	2
			Registrar		Certificate of Death		. No.	ha
	Physici /Medic		1. Decedent's Name (First, Middle, L.	A. MATUL		2. Date of Death Month February		ŧ
	Examin	er	4a. Facility Name (If not institution, gi		4b. City, Town, or Location of	f Death	4c. County of Death	
				e Medical Center Sex 7. Age (In yrs. last b	Towson	24 Hrs. 8. Date of Birth	Baltimore Change Social	_
	Funeral Director			1 M 2 F 91	Yrs. Months Days Hours	Min. (Month, Day, Y	9. Birthplace (State or Foreign	
	land		10a. State 10b. County	10c. City, To	wn or Location		10d. Inside City Limits	;
	with the Maryland a or 28e-f ehow be notified at	0	MARTLAD HARF	-000 Cs	AiR		1 ☐ Yes 2 No)
	with the	Director	10e. Street and Number	0100	10f. Zip Code	10g	. Citizen of What Country?	
		0	1101 Lanowinh	~ R000	21014		0.20	
	ns 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican	in? (Specify Yes or No-	14. Race - American Indian,	
(0	after dea or Items	Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 27 No		, Puerto Rican, etc.)	Black, White, etc.	
33	ell', o	by	3⊠ Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: NHT15	
Maryland 21215-0036	within 72 hours after death ene. then "naturel", or Items 23 be Modical Exemilier mus	Completed	15. Decedent's E (Specify only highest g	Education 16	a. Decedent's Usual Occupation	of working	b. Kind of Business/Industry	
2	thin e	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most life. DO NOT use retired)	G. Working		
7	be filed within tal Hygiene. Id other then event, the M	lo O	13182-		SILF EMPLOY		(JALIOR	
pu	d oth	Be	17. Father's Name (First, Middle, Las	^		r's Name (First, Middle, Mai	iden Sumame)	
<u>Va</u>	2 should be filed withir and Mental Hygiene. Ie marked other then aumatic event, the M	ပ္	Louis	DI ZOWARD.	0 614	100MA D.	BARTALLMO	
a	s 1 and 2 should f Health and Men item 27 le marke other traumatic		19a. Informant's Name/Relationship	(Type, Print) 19	b. Mailing Address (Street and Number	r or Rural Route Number, C	City or Town, State, Zip Code) 315 14	+
	of Health Item 27 other tr		1. JAGA HETEUTY		1) odníwanasto	DAO BELLY	RI IROLANO	
altimore,			20a. Method of Disposition Substitute Burial 2 Cremation 3	Removal from State 20b. Place cemet	of Disposition (Name of ery, crematory or other place)	Date 20	c. Location - City or Town, State	
<u>Ē</u>	permit. Page Department o important: If any injury or once.		*4 □Donation 5 □ Other (Spec	LOR(3005 B	METROLITIAN THEY LAND	
alt	permit. Departimpo		21. Signature of Funeral Tervice Lice	ens	22. Name and Address of Facility	CHAPLI - BE	LAIR, D.A. 21850	
<u> </u>	Per de de de de de de de de de de de de de		LAR KOD		3 NEWPORT DA	IND FOREST I	WELLERAN LILL	l li
as —			23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caused the death. Do y orte cause on each line.	not enter the mode of dying, such as	cardiac or respiratory arrest	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition		FAILURE		Onset and Death	,-
	/Medical	ì	resulting in death)	Due to (or as a consequence	e of):		20000	
	Examiner		Sequentially list conditions	COLON C	ANCER METAI	TADL	3 Marry	2
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):			
	e be executed /sician and e burial-transit	Examiner	trat initiated events	c.				
760,	e exe ian a urial-		resulting in death) Last	Due to (or as a consequence	∍ of):			
376	<u> </u>	lical	•	d				_
89	Attending Physician: The law requires that the death certificate be extracted. r death. ector: Atter this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the buriar.	by Physician/Med	IF FEMALE:					
Вох	th ce tendi	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dear	th 3 Ectopic pregnancy		23d. Date of delivery Month Day Year	
. E	the all	Sici	1 ☐ Yes 2 No 9 ☐ Unknown	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)	· · · · · · · · · · · · · · · · · · ·	Month Day real	
P.0	that the de ed by the detached	Phy						23
Ś	res tha igned be del	by	Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause given in Part I.		cco use contribute to the cause of death?	
oro	v requires been sign should be	ted				1 ☐ Yes	2 No 3 Probably 4 Unknown	
Vital Records,	has b	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of	Э
 	The ate h page	Son				performe 1☐ Yes 2 2	death?	
/ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			of Death (Check only one)		
<u></u>	Physic this of	ပ္	1 ☐ Yes 2 TNo	Hospital: Inpatient 2 ER/C		rsing Home 5 Residence	e 6 ☐Other (Specify)	
_	Jing P	:uo	27. Manner of Death ENatural 5 ☐ Pending	28a. Date of Injury 28b (Month, Day Yeer)	Time of 28c. Injury at Injury Work?	28d. Describe how	injury occurred	
Si O	death.	cati	2 Accident investigati	he .	M 1 Yes 2 I	No		
Division of	ter d irect n by	Certification;	3 ☐ Suicide 6 ☐ Could not determine		farm, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)	
0	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Ce						Ш
	Hosp 4 hot Fune ely fil	Medical	(Check only 2 Medical Ext	Physician: To the best of my knowled aminer: On the basis of examination a	ge, death occurred at the time, date and and/or investigation, in my opinion, deat	d place, and due to the caus h occurred at the time, date	se(s) and manner as stated. a and place, and due to the cause(s)	
	the the the mplet	Jed	one,	and manner stated.				
	To To To To To To To To To To To To To T	-	29b. Signature and title of certifier	CARY 10	29c. License number		Date signed (Month, Day, Year)	
	1	2	1900		1400	/ 6	146 1, 000	
1	(1)		30. Name and address of person wh	o completed cause of death (Item 23a) (Type, Print)	1 1/1 11	Feb 4, 2005	
1	V			MARUEST	(Type, Print) BALTMORE, 70	. 4164	Un. Cory cours	
	Sta Regist		31. Date filed (Month, Day, Year)	8 2005 32. Registrar's Signature	a grant			

Matulionis, Angering

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 200 /Medical Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Itmor If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 F Director 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28e-f show other traumatic avant, the Medical Eraminar must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? APT 150 10e. Street and Number 10f. Zip Code or itams 23e LOUBON Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Newer Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: (3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO/NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) is marked other than Coilege (1-4or 5+) 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Eather's Name (First, Middle, Last) Be should be find Mental F 19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, rint) itam 27 Loc. Location City or Town, State 20b. Blace of Disposition (Name of 20a. Method of Dispositi Department of H important: If ita any injury or ot once. cemetery, crematory or other place) 3 Removal from State 1 Burial 2 Cremation 5 Other (Specify) 4 Donation 22. Name and Address of Facility Faccerol 21. Signature of Funeral Service Licensee 01220 Timonium mod 1093 2325 YORK rd or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Enter the disperse shock, or heart failure. List only one cause on each line Onset and Death tmmediate Cause (Final disease or condition resulting in death) o-vectal Months Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner use as the burial-tran Due to (or as a consequence of): Box 68760. death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☒ No 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Division of Vital Records. 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate has 1 ☐ Yes 2 X No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 2 No 2 ER/Outpatient 3 DOA 6 Other (Specify) 5 Residence P 1 Tyes this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 Natural 2 Accident 5 Pending 1 🗌 Yes investigation Diractor: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie ical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2005 72407 wy, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balto Md 21204 6701 N. Charle 32. Registra's Signature 31. Date filed (Month, Day, Year) State Registrar

			State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 0	05 03704
ı	Physici /Medic		al DIANA ROSE MANDE February 31d	Year 2:20 PM
Ę	Examin Funeral	er	Sinai Hospital of Baltimore Baltimore city	N/A
	Director		5. Social Security Number 217-71-1759 6. Sex 1 M 2 F 30 Yrs. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. July 22, 1974 Usual Residence of Decedent	9. Birthplace (State or Foreign Country) Sudan
	e Marylan e-f show	ctor	10a. State 10b. County 10c. City, Town or Location Waryland Baltimore 0wings Mills	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	n with th	i Dire	10e. Street and Number 10f. Zip Code 10g. Citizen of W 2 Mill Paint Lane Apt 3C 21117 Su	vhat Country? Idan
350	J within 72 hours after death with the Maryland jiens than "natural; or Items 23a or 28a-f show Ite Mccical Examiner mant be malified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Blace 12. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Blace 12. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Blace 12. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Blace 12. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Blace 12. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Blace 12. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Blace 12. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Blace 14. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Blace 14. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Blace 14. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Blace 14. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, etc.) 14. Race Blace 14. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes) 14. Race Blace 14. Was Decedent of Hispanic Origin? (Specify Yes) 14. Was Decedent of Hispanic Origin? (Specify Yes) 14. Was Decedent of Hispanic Origin? (Specif	e - American Indian, k, White, etc.
1215-0036	within 72 hou ne. han "natura e Modicel E	Completed I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker Own	siness/Industry
Iana z	be filed ntal Hygi of other evant.	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumam	Home e)
e, mary	s 1 and 2 should if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Christine Gedim Sister 2 Mill Paint Lane Apt 3C Owings Mills 20a. Method of Disposition 20b. Place of Disposition (Name of Disposition)	
aitimor	permit. Pages Department of I important: if it any injury or o		1 Durial 2 ☐ Cremation 3 ☐ Removal from State Cemetery, crematory or other place)	re, Maryland
ñ	Per Per Per Per Per Per Per Per Per Per		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	ryland 21212
	Physician /Medical Examiner		shock, or heart failure. List only one cluse on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Approximate Interval Between Onset and Death
g/on,	cate be executed hysician and the burial-transit	cai Examiner	d	
O. BOX 6	ath certific	hysician/Medi		e of delivery th Day Year
ras, r	sign sign d be	eted by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	ibute to the cause of death?
ř	The law ate has b page 2 sh	Complete	autopsy performed?	Vere autopsy findings available rior to completion of cause of eath?
ion of vital	tending Physician: Thileath. tor: After this certificate the funeral director, pa	ation: To Be	examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other	
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certific	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined building, etc. (Specify) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number City or Town, State)	
	ne Hosp 24 hou ne Fune bletely fil	edicai	29a. Certifier (Check only one) 1	ner as stated. nd due to the cause(s)
	Mithi To th	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed RES - 000 Februar	(Month, Day, Year) 4 3 (A 200 5
_	2		(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed RES - 000 Februar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ahmed Alsadek, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature	10/2
	Sta Registr		at St. Date filed (Month, Day, Year) 32. Registrar's Signature	

			State of Maryland / Dep	artment of Health and M rtificate of Death	ental Hygie	ena -	3705
	Ξ.,		Decedent's Name (First, Middle, Last)		2. Date of Death	3	. Time of Death
	Physicia /Medic		Walter Anthony Merook		Februar	y 3, 2005	5:45 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Somerford Place	Annapolis		Anne Arunde	
Ĺ	Funeral Director		5. Social Security Number 577-40-1603 Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 1) 3–29–192	(ear) 9. Birthplace Country) Pennsy	(State or Foreign Ivania
	/land		10a. State 10b. County 10c. City, Town or Li	ocation		10d.	Inside City Limits
	72 hours after death with the Maryland natural; or Items 23a or 28e-1 show dical Ezain, per must be notified at	tor	Pennsylvania Schuylkill Pot	tsville			1XYes 2□No
	th the	by Funeral Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?	
	23a	ai	204 Nittany St.	17901		USA	
	tems	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - American I Black, White, etc.	ndian,
36	s afte	y F	1 X Never Married 2 Married 1 X Yes 2 No If Yes, Give 3 Widowed 4 Divorced 1 Year or Dates: W W TT	1 ☐ Yes 2X No Specify:		Specify: White	!
9	tural	ed t	AA.AA. TT	dent's Usual Occupation	16	Sb. Kind of Business/Industr	D/
212	nn na nn na	plet	(Specify only highest grade completed) (Give	kind of work done during most of workin DO NOT use retired)	ng	o. Kind of Business/industr	i y
212	e filed within al Hygiene. I other than " vent, in Max	Completed		nistrative Assista	nt (Catholic Chu	rch
pu	be filed within 72 hours after death with the Marylan ital Hygiene. Idea Hygiene. Idea other than *natural*, or literas 23a or 28e-1 show event, the Marcinal Examinational to notified at	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	uiden Sumame)	
yla	should be nd Mental marked c	ပ္	Stanley Merook	An	na Leasw	icz	
Maryland 21215-0036	12 sh h and 7 Is m reum		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rura	i Route Number, (City or Town, State, Zip Coo	de)
	1 and Healt em 2 ther		Joanna Schuster/ Sister 204 20a. Method of Disposition 20b. Place of Dispo	Nittany St., Potts	sville, 1	PA 17901 oc. Location - City or Town,	State
nor	ages nt of t: If It		1 ☐ Burial 2 XCremation 3 ☐ Removal from State cemetery, cre	matory or other place)		,	
Baltimore,	artme orten injur			Crematory 2-4-0. 2. Name and Address of Facility Geo		Edgewater, M Kalas Funeral	
Ba	permit. Pages 1 and 2 should bu Department of Health and Menta Importent: If Item 27 Is marked any injury or other treumatic er once.			973 Solomons Island			
	}		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac o	r respiratory arres	t, Ap	proximate
	Pnysician		Immediate Cause (Final disease or condition				erval Between set and Death
	/Medical		resulting in death) a Due to (or as a consequence of):				
	Examiner		Sequentially list conditions.				
	sit s	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
_	xecut and II-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8760,	ate be executed hysician and the burial-transit	icalE					
9	ificate g phy as the	edic	0.				
Box	death certifica e attending ph d for use as th	In/M	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□Fetal death 3[23d. Date of delivery	
		Physician/Med	1 Yes 2 No 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (s <i>pecify)</i>		Month Day	Year
P.0	res that the de signed by the a be detached f	Phy	9 DOUKHOWN				
ds,	requires that the een signed by th hould be detache	l by	Part II. Other significant conditions contributing to death out not resulting in the u	inderlying cause given in Part I.		cco use contribute to the ca	
Ö	w require been sig should b	etec	Tattle 10 Journal		-		
Records,	as 2	Completed			24a. Was an autopsy performe	24b. Were autopsy to prior to comple death?	tindings available ition of cause of
Vital		e Co	25. Was case referred to medical	OS Place of Dooth		No 1 ☐ Yes 2 ☐	No
Š	Physicien: this certific ral director.	OB	examiner? 1 Yes 25 No Hospital: 1 Inpatient 2 ER/Outpatien	26. Place of Death	_(Check only one) ne 5 ☐ Residen	ce 6 Kother (Specify)	es vior
J Of	Ph th	n: T	27. Manner of Death 28a. Date of Injury 28b. Time of	The state of the s	28d. Describe how		lung
sior	Attending r death. ector: After by the fune	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	r Att	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	8f. Location (Stre City or Town,	et and Number or Rural Ro State)	ute Number,
Ω	pitel c		ASSOCIATION ASSOCIATION OF THE PROPERTY OF THE				
	Hosp 24 ho Fune stely f	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dear (Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, a westigation, in my opinion, death occurre	ind due to the cau ad at the time, date	se(s) and manner as stated a and place, and due to the	l. cause(s)
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Med	29b. Signature and title of certifier	29c. License number	290	I. Date signed (Month, Day,	Year)
)	/			D57028		7-41-55	
	10-7		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print\		2-4-05	
_	10		ADITYA CHOPRA M.D. 600 RIGGELL	Aur. Stc. 231 An	napol	is, mp. 214	101
	Sta		31. Date filed (Month, Day, Year) FEB 0 8 2005	Aur. Ste. 731 An			
	Registr	ar ,	FED V O LUUS JUREUR JU- A				

			For State Registrar	State of Maryland / Depa Cea	artment of Health and Me	ental Hygier	2005 03706
	Div. et et		1. Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
ı	Physici /Medic			OFAN		02	02 2005 2055 1
П	Examin	er	4a. Facility Name (If not institution, give st	reet and number) -OXBURY ROZA-O	4b. City, Town, or Location of Death		tc. County of Death
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	B. Date of Birth (Month, Day, Yea	NASH INCTON 9. Birthplace (State or Foreign (Country)
	Director		110-10-9710	M 2□F 69 Yrs.	Months Days Hours Min.	(Month, Day, Yea	935 Virginia
	and w		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d, Inside City Limits
	Mary s-f sh	tor	MD NIA	Baltim	ore		1 PYes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show appringnts if item 27 is marked other than "natural", or items 23e or 28e-f show appringnt or other traumatic event, if a Mudical Exertified at annote.	Director	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Country?
	eath w	eral	2808 Rueckert		Was Decedent of Historia Origin? (Spec	U Vog er No	14. Race - American Indian,
0	r item	by Funeral	11. Marital Status 1 Never Married 2 Married	1 ☐ Yes 2 WiNo	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ican, etc.)	Black, White, etc.
5-0036	urai', c	d by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 102 No Specify:		Specify: Black
<u>.</u>	n 72 h	lete	15. Decedent's Educi (Specify only highest grade	completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b.	Kind of Business/Industry
212	d with giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	hanic	1-1	uto
g	be file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)	0	18 Mother's Name	(First, Middle, Maid	en Surname)
Maryland 2121	should ind Men s marke umatic	ဥ	19a. Informant's Name/Relationship (Typ	O Print) 19h Maili	ng Address (Street and Number or Rural	e Wor	MICY
	and 2 sho ealth and n 27 is m		Shijuana Maya	- Hanson 280	8 Rupckert Ave	Balto	MO 2/2/4
Sre,	of Health of Health item 27		20a. Method of Disposition	20b. Place of Dispo	osition (Name of Da matory or other place)	te 20c.	Location - City or Town, State
Baltimore,	Pages ment of I tant: if its		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 9 ☐ Other (Specify)	moval from State Mt. Carn	nel Cemetery 2-9-0	05 Dur	ndalk, mp
Ba	permit. Pages Department of Important: If ii any injury or o		21. Signature of Funeral Service Licenson	22	2. Name and Address of Facility	nc-16:14	21229
			23a. Part. Enter the disease, or complic	ations that caused the death. Do not ent	ter the mode of dying, such as cardiac or	respiratory arrest,	Approximate
	Physician		shock, or feart failure. List only one Immediate Cause (Final disease or condition	FM STAGE	LIVER DISEASE	- 10100	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	1	1017	-17051> Zyeons
	Lxammer	J.	Sequentially list conditions, b.	Due to (or as a consequence of):	PATITIS (Ba	nd C)	
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
Ö,	cate be executed physician and the burial-transit	Exa	resulting in death) Last	Due to (or as a consequence of):			
98760	icate b physic s the b	dlcal	d.				-
9 xo	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy	7		23d. Date of delivery
P.O. Box	e deatl the atte	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		Month Day Year
<u>.</u>	that the	/ Ph	Part II. Other significant conditions cont	nbuting to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
Vital Records,	w requires that been signed t should be det	ed b	DIABETES M	IELLITUS		1 🗆 Yes	2 No 3 Probably 4 □Unknown
ဝ၁	ne iaw re has bee ge 2 sho	plet				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u>س</u>	: The cate h	Соп				performed?	death?
	sician: Th certificate irector, pag	Be c	25. Was pase referred to medical examiner? 1 ★ Yes 2 No D. WEEKS	espital:	26. Place of Death (
0	g Physier this	n; To	27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outpatier 28a. Date of Injury (Month, Day Year) 28b. Time o Injury	TO DOA 4 INdising Home	e 5 Hesidence 3d. Describe how in	6 Other (Specify) NFIRMARY jury occurred
Sior	eath. or: Aft	catlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(World), Day 7 Sally Hillion	M 1 Yes 2 No		
Division of	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office 28	Bf. Location (Street: City or Town, Sta	and Number or Rural Route Number, ate)
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physi	cian: To the best of my knowledge, deat	h occurred at the time, date and place, an	d due to the cause	(s) and manner as stated.
	To the Hic within 24 To the Fu	ledical	one)	er: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred	d at the time, date a	nd place, and due to the cause(s)
	To To	Σ	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
	1		30. Name and address of person who con	ppleted cause of death (Item 23a) (Type,	Print)	<i>></i>	2/2/2005
	\		18601 ROXA	MY ROAD, ITA	HGERSTOWN, 1	MO 21	746
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 8	32. Registar's Signature	porte		
E.	negisti	al	i in to				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Clarence 2:05A M John Maybin, Jr. 02 OS /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 08.02. Birthplace (State or Foreign Country) **Funeral** Days 216.30.372 Months Min 178 M 2 ☐ F Hours Director Yrs. Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Baltimore MD Baltimore Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 362 Beaumont Avenue 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 DKNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ns any injury or other traumatic event, the Medic 2006. General Motors Elementary/Secondary (0-12) College (1-4or 5+) 12tharaac Supervisor Paint Dept. NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) J. Maybin, Sr. (larence WIKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. Maybin Avenue Baltimore MD 21228 362 Berumont Anita 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State Randallstown, MD King Park 02.07.05 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Vingen C. Greene Funeral Sentices 21. Signature of Funeral Service Licenses 551 Baltimore Naturnal File Baltimore MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Bety Immediate Cause (Final disease or condition resulting in death) Over any Site **Physician** month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?
1 \(\text{Yes} \) 2 \(\text{No} \) 23d. Date of delivery 3 Ectopic pregnancy Day Month 4 Pregnant at time of death o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 2 X No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1X Natural investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) FEB 8 2005

Thun

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

LAKENDE MAYBIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) affeen **Physician** Mealey Ebyvary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hospice Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) D4 · Clp · [9]9 9. Birthplace (State or Foreign Country) **Funeral** 85 yrs. Days Min 215-18-636 1 ☐ M 2 🕱 F Director MD Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-1 ehow other treumatic event, the Medical Examinar must be notified at MD Baltimore 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 603 N. Pulaski Street 21217 Completed by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married lánd 21215-0036 1 Yes 2 No Specify: BLACK 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "n any injury or other treumatic event, the Meall 2006. Elementary/Secondary (0-12) College (1-4or 5+) Custodian 11th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robinson EISIE Bel John Baltimore, Maryl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kobinson 603 N. Pulaski William Street Baltimore MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1

Burial 2 □ Cremation 3 □ Removal from State 02.07.05 Baltimore MD MT. ZION * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Vaughn C. Greene Funeral Services
551 Baitimore National Pike Baitimore MD 21229 23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** emention 0 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last ding physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant signed by the atter d be detached for u 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably been si 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 ☑ No this certificate 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₽No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) After thi 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Matural 5 Pending s after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I Till Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2/2/2005 M0827 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) ST Paul Baltimore 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiege 03709 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February 5, 2005 Corinne Raphe1 Muller 9:17 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Oak Crest Care Center Parkville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept. 22, 1916 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 ☐ XF MaryTand 88 Yrs 199-05-5914 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or items 23a or 28e-f show any lighty or other treumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🗓 No Baltimore Parkville Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 8820 Walther Blvd. Belmont 2209 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 ğ 1 ☐ Yes 2 ☐ (No Specify: Specify: 3 Nidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 3^{College (1-4or 5+)} Elementary/Secondary (0-12) Registered Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Corinne Fleury Henry Raphe1 ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 Tregarone Road Timonium, Maryland 21093 Gus Muller / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem. Gds.2/8/05 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furjeral Service Ligenses 22. Name and Address of Facility 1050 York Road Towson, Md. 21204 Ruck Towson Funeral Home, Inc. cen at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in each line. 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Physician teriosclerar cardinas culardisese Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner ettending physician end for use as the burial-trensit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as e consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? Unknown 1 TYes 2 No 3 ☐ Probably 24b. Were autopsy findings eveileble prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? No DK 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 26 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftert 5 ☐ Pending investigation Natural Accident ours efter death. Inled In by the fur 1 □ Yes 2 □ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital within 24 hours e To the Funeral C completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) U Name and address of person who completed cause of death (Item 23e) (Type, Print) aulinermi 8800 Walther Blud 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Elem & foot Registrar

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Ma	arylan		artment <i>rtificate</i>			nd Me		iene og. Nö. O	05	37	11
	Physici /Medic		Decedent's Name (First, Middle, Morris	Last)		Na	sh				2. Date of Deat Month	h Day	Year 2005	3. Time of	
)	Examin		4a. Facility Name (If not institution, S FRANKLIN SQUAT	RE HOSPITAL				SEDI	41E			6	unty of Death BALTIMO	ORE	
	Funeral Director		5. Social Security Number 219–28–0188 Usual Residence of Decedent	. Sex 7. Age 7.		last birthday) Yrs.	If Under 1 Months		If Under 2 Hours	Min.		Date of Birth (Month, Day, Year) 2-8-34 9. Birthplace (State or Foreig Country) Md			or Foreign
	Maryland f show	tor	10a. State 10b. County	NA	10c. City	y, Town or Lo							10	d. Inside Ci	ity Limits
	with the sor 28a.	Funeral Director	10e. Street and Number	D.d.			10f. Zip C		<i>C</i>		1	-	of What Count	ry?	
	death	nerai	5208 Saybrook	12. Was Decedent I	Ever in U.	.S. 13.		2120		in? (Spec	rify Yes or No- lican, etc.)	14.	SA Race - America		
9800	ours after ral', or Ite Exertine		1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 Tyes 2 N If Yes, Give Year or Dates:	lo	ĺ	1 Yes 2			Puello H	ilcan, etc.)	1	Black, White, e	ack	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. Id other than "naturel", or Itams 23a or 28a-f show avant, the Medical Exarting must be redified at	Completed by	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5	+)	(Give	dent's Usual kind of work DO NOT use UCK Dr	done dui retired)	ring most	of workin	g		of Business/Ind	ustry	
1d 2	illed Hygi thar nt, t	Be Co	10th grade 17. Father's Name (First, Middle, La	st)		TT	uck Di			's Name	(First, Middle, M				
ýlar	should be tind Mental is marked o	To B	Thomas	с.	Nas					iola			Conyer		
	12 ad		19a. Informant's Name/Relationship Brenda Nash	Wife		129	Willo	w Be		c. Ag	Route Number,	Owi	ngs Mil	ls, I	1117 Md.
Baltimore,	000		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		0	Place of Dispo emetery, crea d. Vet	natory or oth	of erplace)	1	_{Da} 2–9–0			on-City or Tov nsville		
Balt	permit. Pag Department Important: b any injury o once.		21. Signature of Funeral Service Lic	Tea	>		Name and March	F.H	. Eas	st	llol E	E. No	re, Md. rth Ave	2120	02
7	Physician		23a. Part1. Enter the disease, or of shock, or heart failure. List or immediate Cause (Final disease or condition	implications that caused by one cause on each ling BRON CHI							respiratory arre	est,		Approximat Interval Bet Onset and I	ween
	/Medical Examiner		resulting in death) Sequentially list conditions.	Due to (or as b. Pulmor	YAR	Y EM	BOLISM	1							
,	ificate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c											
68760,	ficate be physicia ss the buri	edicai	A	d											
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be deteched for use as the bural-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ ∀es 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	I death 3	Ectopic preg Other (spec			<u>-</u>		23d.	Date of deliver Month [•	/ear
	w requires that been signad b should be deta	by	Part II. Other significant condition.	s contributing to death be	ut not resi	ulting in the u	nderlying cau	se given	in Part I.		23e. Did tob	_4	contribute to the	cause of d	
Vital Records,	The law requirate has been page 2 should	Completed				-			_		24a. Was ar autops perform 1 \(\text{Yes} \) 2	v	4b. Were autop prior to com death? 1 Yes 2	pletion of a	available ause of
Vita	Physician: The this certificate har ral director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 X Inpatie	ot 2	ER/Outpatier	nt 3□ DOA	Other:			(Check only one		Other (Const.)		
ion of	유 부 등		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		28b. Time o Injury		i. Injury a Work?		28	Bd. Describe ho				
Division	at or Atta s after dea Il Diracto	Certification:	3 Suicide 6 Could no 4 Homicide determine		ury - At ho	ome, farm, str	eet, factory, o	office		28	Bf. Location (Sti City or Town	reet and N , State)	umber or Rural	Route Num	ber,
	To the Hospital or Attanding Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical (29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examina	wledge, deat tion and/or in	h occurred at vestigation, ir	the time, n my opin	, date and nion, death	place, ar occurred	nd due to the ca	use(s) and ite and pla	I manner as sta ce, and due to	ted. he cause(s)
	To the comp	×	29b. Signature and title of certifier	7100000		14	29c. l	License n	10mber	7	25		gned (Month, D		
Í	14/	2	30. Name and abdress of person wi	no completed cause of d	eath (Item	23a) (Type,	Print)						4-20		
+	Sta	ate.	Dr. GLENN MEIN 31. Date filed (Month, Day, Year)	INGER, 90			in sau	MRE	DR	IVE	, BALTI	MORE	MD	2123	7
	Registi	_		8 2005	_	K	Sound								

	1	For Stata Registrar	State of Ma	aryland / I	-	rtment of H	leaith and M Death	lental Hy	giene	Z11115	03712
		1. Decedent's Name (First, Middle, L.	ast)					2. Date of D	eath		3. Time of Death
Physician /Medical	_	Virginia M.	D'Neill					FEB	OE	2005	51624 1
Examiner		la. Facility Name (If not institution, gi	ve street and number)	Λ.		4b. City, Town, or	Location of Death	_	4c.	County of Death	
		5. Social Security Number 6.	HOSPIT	e (In yrs. last bi	thday)	If Under 1 Year	If Under 24 Hrs.	Doto of Bi	irth	n/:	aplace (State or Foreign
Funeral Director			1 ☐ M 2 🔀 F	85	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D	ay, Year) 2 5 10		vland
		Usual Residence of Decedent		· · · · · · · · · · · · · · · · · · ·	1			pa carry .		/W Hai	
show		10a. State 10b. County		10c. City, Tow							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
vith the Mar t or 28a-f si be notified	3	Maryland Baltin	nore		Cator	nsville			40- 00	izen of What Co	
with la or l		10e. Street and Number 912 South Rollir	ac Pood			10f. Zip Code 21 2 2 E	1		Tog. Cit		untry?
036 Ours after death with the Maryla rail, or itams 23a or 28a-f shot East infertous the motified at East infertour and Director	2	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. W		ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or N	0-	USA 14. Race - Amer	
or ital		1X Never Married 2 ☐ Married	Armed Forces?				n, Mexican, Puerto Specify:	Rican, etc.)		Black, White	
15-003 72 hours a "natural", c		3 Widowed 4 Divorced	If Yes, Give Year or Dates:							Specify:	White
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. the than "natural", or items 23e or 28e-f show ent, the Mayled Examination was be notified at the Completed by Funeral Director	200	15. Decedent's E (Specify only highest g	rade completed)		(Give F	ent's Usual Occupa aind of work done of ONOT use retired	during most of work	ing	16b. Ki	ind of Business/I	ndustry
withly sene.		Elementary/Secondary (0-12)	College (1-4or 5	5+)	me. D	Manager	•		Te	lephone	Company
be filed tal Hyging of other event, I	5	17. Father's Name (First, Middle, Las		1		3	18. Mother's Name	e (First, Middle			oompany .
arylan should be and Mental marked o umatic eve	2	Walter F. O'N	leill			;	Beati	rice J	I. M	asilek	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Marial Hygienshi if item 27 iemarked other than "natural", or any injury or other traumatic event, the Marical Exami once. To Be Completed by F		19a. Informant's Name/Relationship		. 11			and Number or Run				ip Code)
and 2 and 2 health m 27 her tra	-	Mrs. Mary Sue Sny	der (Niece				ge Road To				
Pages 1 Pent of H Int. If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State	cemete	ry, crem	ition (Name of atory or other plac	e)	Date		ocation - City or T	
timen rimen rimen rimen rijury	1	'4 □ Donation 5 □ Other (Spec	4 /	Parkuoo		,	2/10/2	2005	Balt	imore Mer	ryland 21274
Balti permit. Departi importe any inju		21. Signature Financial Septime Too	usk Ir		Ruc		uneral Home			ork Road	
		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused y one cause on each lir	the death. Do	not ente	r the mode of dying	g, such as cardiac	or respiratory a	arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	_a b8	mel ob	かったい	tion					Onset and Death
/Medical Examiner		resulting in death)		a consequence		a de la compaña					12 hours
5	5	Sequentially list conditions,	0	a consequence		neumonia					1200013
executed or and ial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
		resulting in death) Last	Due to (or as	a consequence	of):						
	2		d								
	2	IF FEMALE:									
ords, P.O. Box 6. requires that the death certific een signed by the attending phould be detached for use as ested by Physician/Mee	2	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal death		Ectopic pregnancy			1	23d. Date of deliver Month	very Day Year
P.O. that the de detached the z	7315	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5□	Other (specify)					
P. P. that the that the detack		Part II. Other significant conditions	contributing to death b	ut not resulting i	in the un	derlying cause give	en in Part I.	23e. Did	tobacco u	ise contribute to	the cause of death?
rds, Fruds,							10	Yes 2	☑No 3☐Pro	bably 4 DUnknown	
Il Records Il Records The law requires page 2 should be								24a. Was		24b. Were aut	opsy findings available ompletion of cause of
I Rec I Rec The law	5							auto perfe 1 🗀 Yes	ormed? 2 No	death?	
f Vital Re valcien: The lis certificate had director, page	0	25. Was case referred to medical examiner?					26. Place of Death				
	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	- 1			4 Nuising No				ify)
Attern tunerr	5	27. Man r of Death 1 Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	y Year) 28b.	Time of Injury	28c. Injury Work		28d. Describe	how injur	y occurred	
Division or Attending after death. Director: After in by the funeertilf cation.	Cal	2 Accident investigate 3 Suicide 6 Could not	h a	unr. At home fr	arm etro		Yes 2 □ No	28f Location /	(Street an	d Number or Ru	ral Route Number.
Division of Division of Itel or Attending Presented and Division of Division o		4 Homicide determined	d 28e. Place of Inju- building, etc	c. (Specify)	aim, stie	et, lactory, office		City or To	wn, State)	ar rodio romber,
Hosp 4 hou Funer iely fill	- La	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	Physician: To the best of aminer: On the basis of and manner sta	f examination ar	e, death nd/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occurr	and due to the ed at the time,	cause(s) , date and	and manner as	stated.
To the within 2 To the complet	2	29b. Signature and title of certifier	L-MD			29c. License	e number			e signed (Month	
		> to	1.00			D4-	7353		rele	orvary 5	5,2005
14		30. Name and address of person who	completed cause of d		(Туре, Г	Print) although	e, Maryla	nd z	122		
State		31. Date filod (Month, Day, Year)		ar's Signature							
Registrar		FEB 8	2005	en b		heels !					
DHMH 17 Day 1/2001	4			_		-					

Lavina R. Peterson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-0852 1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death

State of Maryland / Department of Health and Mental Hygiene G841 3-2-05 tas

Certificate of Death AKG 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day ERSON AVINA Month **Physician** February 2005 6:54 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4215 Chatham Road Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 1 F VIKGINIA 213.78.093 Yrs. Director Usual Residence of Deceden the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Show rthan "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at NEU 1 Yes 2 □ No by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number death Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 MDivorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. De NOT use retired)

HSHER 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "ns any injury or other traumatic event, The Madis. Once. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) IJNK 18. Mother's Name (First, Middle, Maiden Su Be ပ or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number LEDBEHEK BATTIMORE, MD DANGHTEX 21206 Date Place of Disposition (Name of 20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee JATIONAL YIKE BACTO, MO 21229 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Narcotic Intoxication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician requires that the death certificate be Physiclan/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ŏ Month Day Year 4□Pregnant at time of death 5 Other (specify) Yes the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by þe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2□ No 1 Yes 2 100 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ity) at scene unk Hospital: 1 | Inpatient | 2 | EP/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No ို 28b. Time of **unk** 28c. Injury at Work? 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Injury 5 Pending 1 Natural death. М 1 ☐ Yes investigation 2 Accident 2-2-05 6 Could not be 28f. Location (Street and Number of Rural Boute Number, City or Town, State 215 Chatham Rd. 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide

or Attending Physician: completely filled in by the funeral after death To the Hospital o within 24 hours aft To the Funeral Di

House Baltimore, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Sigpati e and title of certifie 29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E. February 2, 2005

and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

Medical

31. Date filed (Mo.

		For State	State of Maryland				Mental Hy	giene	15 03711
		Registrar 1. Decedent's Name (First, Middle, Last)		Ceni	ficate of D	Jeatn	2. Date of De	Reg. No:	3. Time of Death
Physic). Parke	r Sr			Month	Day	Year 2005 1:08 P M
/Med Exami		4a. Facility Name (If not institution, give			b. City, Town, or I		h	4c. County	
		SINATHO			BA 1-	Timor		N/A	
Funeral Director		5. Social Security Number 6. Security 120-03-5806	7. Age (In yrs. Ia M 2 F 89		If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Da	y, Year)	9. Birthplece (State or Foreign Country) N. Carolina
		Usual Residence of Decedent 10a. State 10b. County	100 City	. Town or Local	No.				
Aaryla f shov	ŏ	Md. N/A		altimo					10d. Inside City Limits 1 □XYes 2 □ No
r 28e-	rect	10e. Street and Number	Ь	artimo	10f. Zip Code			10g. Citizen of V	Vhat Country?
th with	aD	3504 W. Fores	st Park Ave.		21216			USA	
inc, with year of a fair of a factory after death with the Maryland of the alth and Mental Hygiene. It health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23e or 28e-f show other treumetic event, Ite Marical Examiner must be mailtied at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1		s Decedent of His es, specify Cuban Yes 2X No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		e - American Indian, ck, White, etc. :: Black
72 ho	Completed	15. Decedent's Edu (Specify only highest grade	cation a completed)	16a. Deceder (Give kir.	nt's Usual Occupated of work done du NOT use retired)	tion uring most of wo	rking	16b. Kind of Bu	usiness/Industry
within and the n	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		Salema			Auto D	ealers
Hygied other	40	12 17. Father's Name (First, Middle, Last)		Cal			me (First, Middle,		
Lal y lallu L L L L L L L L L L L L L L L L L L	To B	Harry Par	ker			Lill	ie Pa	rker	
and Name	1	19a. Informant's Name/Relationship (Ty	эө, Print)		Address (Street ar				
C, IV		Bernice Parker 20a. Method of Disposition		3504 ace of Dispositi		st Par	k Ave,E		ore, Md. 21216 City or Town, State
permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tre once.		1 XBurial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	metery, cremai odlawi	ory or other place				ore, Md.
permit. Departn Importe eny inju		21. Signature of Funeral Service License L L L Oyd M. Este	30			thers			A. Taryland 2121
		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death.	. Do not enter	the mode of dying	w Plac , such as cardia	e, Baltl c or respiratory ar	more, M	Approximate
Physician		shock, or heart failure. List only or immediate Cause (Final disease or condition	ASPIRAT	ion		umon			Interval Between Onset and Death
/Medical		resulting in death)	Due to (or as a consequent	ence of):	1700				
Examiner		Sequentially list conditions, if any, leading to immediate).						
ted nsit	nlne	rf any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	ence or):					
execu an and rial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
icate be executed physician and sthe burial-transit	dlcal	C.	1						
	0	IF FEMALE:	3c. If yes, outcome of pregnan	nov.					
death death death death death death	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Fetal of 4 Pregnant at time of de	death 3□Ed	ctopic pregnancy ther <i>(specify)</i>			Mor	e of delivery nth Day Year
by the	hys	9 Unknown	9⊡ Unknown						
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	þ	Part II. Other significant conditions con	tributing to death but not resul	lting in the unde	artying cause giver	n in Part I.			ibute to the cause of death?
w requires to been signed should be	eted								3 Probably 4 ⊠Unknown
2 8 8	Completed						24a. Was autop perfo	isy p	Vere autopsy findings available prior to completion of cause of leath?
ung Physicien: The lav Alter this certificate has funeral director, page 2	e Co	25. Was case referred to medical				26 Place of Do	1 ☐ Yes	2 X No 1	Yes 2000
ysicie is cert direct	0 8	examiner?	lospital: 1 ☐ Inpatient 2x E	- ER/Outpatient	3 □ DOA Other	r	lome 5 ☐ Resid		er (Specify)
ding Phys	I.I.	27. Manner of Death ↑ Natural 5 ☐ Pending		28b. Time of Injury	28c. Injury Work	at ?	28d. Describe h	ow injury occurr	ed
tending death. tor: Afte the fune	catle	2 Accident investigation 3 Suicide 6 Could not be				es 2 No			
el or At s after d il Direct	Certification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, street)	t, factory, office		28f. Location (S City or Tow	Street and Number m, State)	er or Rural Route Number,
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director, to	Medical	29a. Certifier (Check only one) Certifying Physical Check only 2 Medical Exami	sician: To the best of my knowner: On the basis of examinational and manner stated.	vledge, death or ion and/or inves	ccurred at the time stigation, in my opi	e, date and place inion, death occu	e, and due to the curred at the time,	cause(s) and mad date and place, a	nner as stated, and due to the cause(s)
To th Withir To th	×	29b. Signature and title of certifier	7/		29c. License				(Month, Day, Year)
1	7	many !	hysiciAn) 220) (Time 5)	D00	5455	8	tebru	apy 6 2005 20,MD 21215
QT'		Freversck Bi	mpleted cause of death (Item	23a) (Type, Pri	W-Belv.	edere	Ave B,	4 1 times	2e,M021215
Si Regis	tate trar	31. Date filed (Month, Day, Year) FEB 0 8 2	32. Regimman's Signatu	ure	1 -				,
DHMH 17 Rev 1/	4*	. 20 00	way your	15 19	news)				

			For	State of Ma					nd Mental		_	03715	
			1 - State Registrar				icate of L			Reg. No	000	03/13	
	Physicia	an	1. Decedent's Name (First, Middle, Last)	0					2. Date of Month		y Year	3. Time of Death	
	/Medic		FRANK, FORROST, PUSKAS							02 01 2005 1:17 14			
	Examin	er	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ALL mure VA Medical Center BALTIMORE							4c. County of Death N/A			
	Funeral	-5	5. Social Security Number 6. Sex		(In yrs. last b		Under 1 Year	If Under 2	4 Hrs. 8. Date of	f Birth Day, Year		thplace (State or Foreign	
	Director		219 - 40 - 3363	M 2□F	60	Yrs. Me	onths Days	Hours	Min. July	19, Year,	944 Ma	aryland	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Introduction: if flem 3718 marked other than "natural", or items 23a or 28a-1 ahow any injury or other treumatic event, the Maryleal Examination at be notified at once.	Funeral Director	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	um or Locatio	20					10d. Inside City Limits	
			Maryland Baltimore Essex									1 ☐ Yes 2 XNo	
										10g. Ci	tizen of What Co	ountry?	
		ai D	500 South Marlyn Avenue Apt. 1B 21221 USA										
	r dea	ıner	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (5 lf Yes, specify Cuban, Mexican, Puer						in? (Specify Yes of Puerto Rican, etc.	cify Yes or No- lican, etc.) 14. Race - American Indian, Black, White, etc.			
36	s afte	by Fu	1 Never Married 2 Married	0 1966 1980 1□ Yes 2♥ No Specify:						Specify: White			
8	tural	ed t	15 Decedent's Education 16a Decedent's Usual Occupation							16b. K	16b. Kind of Business/Industry		
215	hin 72 s. nn "na	To Be Completed	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired) Elementary/Secondary (0·12) College (1-4or 5+)						of working		United States		
2	ed wit		4 Mechanic							Air Force			
ng	be fill had oth even		17. Fathers Name (First, Middle, Last) 18. Mother's Name							(First, Middle, Maiden Surname)			
Maryland 21215-0036	d Men d Men narke natic									Dobbins Il Route Number, City or Town, State, Zip Code)			
	ith an 27 la r		Silas R. Still, So		1	•	,		Lover Cou			s, Md 21401	
Baltimore,	t Hea of Hea item othe		20a. Method of Disposition				n (Name of ory or other place	100000	Date	-	ocation - City or		
	Page		1 ☐ Burial 2 📉 Cremation 3 🗀 R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Metro	Crema	atory I	nc. C)2/04/05	Ba	ltimore	, Maryland	
3alt	Departi Import any inj once.		21. Signature of Funeral Service License	98		Crer	me and Addres	s of Facility	y Of Mar	yland	Inc.		
	7034 Q		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society Of Maryland Inc. 29. Prederick Road Baltimore, Maryland 21228 23. Part Folia: the disease or completions that caused the death. Do not enter the mode of thing such as cardiag or respirators are recommended.										
1			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final									Interval Between	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) ATHENOSCUSION D(SMSE) Due to (or as a consequence of):										
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):										
	be sit												
	icate be executed physician and s the burial-transit		Cause (Disease or injury that initiated events c. Due to (or as a consequence of):										
760,	te be executed ysician and te burial-transit	caiE	d										
9		by Physician/Medi											
Box	death certifica e attending ph d for use as th		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown								23d. Date of delivery		
0.	ne dea the at hed fo	/sici								Month Day Year			
۵.	The law requires that the de ate has been signed by the a page 2 should be detached f	Ph)	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did t							Did tobacco	obacco use contribute to the cause of death?		
Records,	w requires that been signed b should be det		DIARETTE							☐Yes 2	Yes 2 No 3 Probably 4 Unknown		
O O	s beer	Certification; To Be Completed								Vas an		utopsy findings available	
	The law ate has page 2:								103/	iutopsy erformed? es 2□No	death?	completion of cause of	
of Vita	ttending Physicien: death. stor: After this certifice the funeral director.		25. Was case referred to medical examiner?						of Death (Check o	nly one)			
			1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury 28c. Injury at							me 5 Residence 6 Other (Specify)			
										28d. Describe how injury occurred			
NS.			3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,								ural Route Number,		
á	s after s after el Direc		4 ☐ Homicide building, etc. (Specify) City or Town, State)										
	Hospit 4 hour Funer ely fill	edicai	29a. Certifier (Check only 2 Medicel Examil	pr: Un the basis of i	examination a	ge, death occ	curred at the tim	e, date and pinion, death	place, and due to	the cause(s) and manner as	stated.	
	To the Hospital or Attenwithin 24 hours after deatl To the Funerel Director:	Medi	(Check only one) 2 Medicel Example: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated. 29b. Signature and title of certifier 29c. License number 29d.										
1	29c. License number 29c. L							386	86		FO3 C	FOB DI Zani	
	YX.		30. Name and address of person who co	moleted cause of de	ath (Item 23a) (Type, Prin	t)		Λ				
	ŋ		DAVIG	JEM	1900	100	1 GREEN	ve Sta	ee + BAC	4 no ce	M) 2	20/	
	Sta Registr	_	31. Date filed (Month Day Year) 8 2	005 32. Heathra	rs Signature	k R	and a						

219-40-3363

		1- State of Maryland /		irtment of H		ind Mei	ntal Hy	6	GUU2	03716	
		Registrar 1. Decedent's Name (First, Middle, Last)	001	incate of L	- Cairi	2.	Date of De	Reg. No	0.	3. Time of Death	
Physici /Medic		Salvatore Rosario Piraro				F.	Month 2 WV UA	Da VY	03, 2000	- 10	
Examin	er	4a. Facility Name (If not institution, give street and number) 600 Samavitau (+0501+a)		4b. City, Town, or Baltim				40	County of Dea	th	
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last to the security Number 6. Age (In yrs. last to the security Number 6. Age (In yrs. last to the security Number 6. Age (In yrs. last to the security Number		If Under 1 Year Months Days	If Under 2	24 Hrs. 8. Min.	Date of Bir (Month, Da VICh	rth ay, Year,		thplace (State or Foreign	
Director		218-54-1936	Yrs.			Ma	irch :	31,1	949 Ma	ryland	
yiand how		10a. State 10b. County 10c. City, To	wn or Lo	cation						10d. Inside City Limits	
e Mar	ctor	Maryland Baltimore								1 □ Yes 2 No	
with the Maryland a or 28a-f show	Director	10e. Street and Number	Hall Blud Ant 102				10f. Zip Code 1 21236				
death w	Funeral	9522 Perry Hall Blvd., Apt. 103	12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify						U.S.A	<u> </u>	
be filed within 72 hours after death with the Maryland tal Hygiene. Ital Hygiene. or itams 23a or 28a-f show of other than "natural", or itams 23a or 28a-f show event, Ita Medical Examinativity in the follified at	by Fur	1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give		Yes, specify Cuba	n, Mexican, Specify:	, Puerto Ric	an, etc.)		Black, White		
2 hour		3 Widowed 4 Divorced Year of Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b.							Specify: White D. Kind of Business/Industry		
thin 7; e. an "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) (Give kind of work done during most of working life. DO NOT use retired)								
led wi tygien har th		12th Grade	Rea	tail Mana	~	1. N	2 A E 1 4 E		partmen	t Store	
id be fi ental H ked of	o Be	17. Father's Name (First, Middle, Last) Santo Piraro				r's Name (F rah		, maidei mart			
shoul and Me mari	Ě		9b. Mailin	g Address (Street a	and Numbe	r or Rural R	oute Numb	er, City	or Town, State,	Zip Code)	
and 2 salth a n 27 is						.vd., 1	Apt.	102,	Balt.,	MD 21236	
ges 1 t of Hr if itar or oth		1 Cal Dulla: 2 Craillation 3 Individual Iloni State		sition (Name of natory or other place		Date			ocation - City or		
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if itam 27 is marked other than any injury or other traumatic evant, Itam Magnee.		'4 ☐ Donation 5 ☐ Other (Specify) Parku 21. Signature of Funeral Service Licensee		Cemetery Name and Addres					timore, Ineral H	Maryland	
permi Depar impor any ir		Buin G. Wille		105 Belai						unes	
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between									
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)								Onset and Death	
Examiner		Due to (or as a consequence	ce of):								
7 E	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury but stitutes west to the conditions of the condi	e of):								
be executed ician and burial-transit	Examine	that initiated events	Due to for as a consequence off:								
cate be executed physician and the burial-transit		d d	Due to (or as a consequence of):								
	ledicai	0.									
eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea	ith 3	3 ☐Ectopic pregnancy				23d. Date of delivery Month Day Year			
The law requires that the death certifities has been signed by the attending vage 2 should be detached for use as	Physician/Me	1 Tes 2 No 9 Unknown 5 Other (specify) 9 Unknown							monar Bay roas		
es that igned by be deta	by Ph	Part II. Other significant conditions continuiting to death but not resulting in the underlying cause given in Part I.								oute to the cause of death?	
w require been sig should b		Peripheral Vascular Disease, Anemia, 24a. Was an autopsy						Yes 2	2 No 3 Probably 4 Unknown		
e 2 sh	Completed	Peripheral Vascular Disease	AV	remia,			24a. Was autor	DSV	prior to	itopsy findings available completion of cause of	
		Hyper tension					1 Yes	2 No	death? 1 ☐ Yes	2□ No	
Physician: r this certific ral director.	o Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
ding Phy I. After this funeral o	 -	27. Manner of Death 28a. Date of Injury 28b	. Time of Injury	28c. Injury Work					ry occurred	cny)	
Attanding is death. ector: After by the fune	catic	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 □ Accident investigation 3 □ Suicide 6 □ Could not be									
To the Hospital or Attanding Phywithin 24 hours after death. To the Funaral Difector: After the completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						ocation (Street and Number or Rural Route Number, City or Town, State)			
spital		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
the Ho in 24 in the Fu	ledicai	one) 2 Medical Examiner: On the basis of examination a and manner stated.	and/or inv	estigation, in my op	inion, deat	h occurred a	at the time,	date and	d place, and due	to the cause(s)	
To with	Σ	29b. Signature and title of certifier	111	29c. License	number	5557		29d. Da	ite signed (Mont	h, Day, Year)	
m		30. Name and address of person who completed cause of death (Item 23a) (Tuna	Print)	000	0)/		rch	sviny	3 2005	
		29b. Signature and title of certifier 29c. License number REG 000 58570 FCD VURY 5 3005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V 1 A Y Lia G 1 C M N 5601 LOCH RAVEN BIVA. BALLIN OR, MID 21239 31. Date filed (Month, Day, Year) 32 Registrar's Signature									
Sta	-	31. Date filed (Month, Day, Year) 32 Registrar's Signature			-			-			
Registr	ar	FFB 0 8 2005 Blees B	Ans	12/							

			1 - For State Registrar	State of Marylar	nd / Depa	artmer		ealth ar	nd Menta		12005	5 037	17
5	VFC	*	1. Decedent's Name (First, Middle, Las	t)						e of Death		3. Time of	Death
r	Physici	~	DELORIS M.	PICKETT					Feb	ruary	Day Ye 1, 2005		М
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City	, Town, or	Location of			4c. County of E		
	aaniii	,đ	Prince Georges Ho	spital		Che	ver1	y			Prince	Georges	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday)	If Unde	r 1 Year	If Under 24	4 Hrs. 8. Dat	e of Birth onth, Day, Yes		Birthplace (State of Country)	r Foreign
3	Director		434-44-0990	□M 20XF 74	Yrs.	Months	Days	Hours		1y 1,19		ouisana	
	۶ _		Usual Residence of Decedent									`	
	show	_	10a. State 10b. County	106. CI	ty, Town or Lo	ocation						10d. Inside Cit	•
	Ba-f	cto	Md. Prince G	eorges C	apito1							1 X Yes	2 [_] NO
	or 2		10e. Street and Number				p Code			10g.	Citizen of Wha	t Country?	
	ath w	Funeral Director	7242 G. Street				743				S.A.		
	er de	une	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	l.S. 13.	Was Dece If Yes, spe	edent of His ecity Cubar	spanic Origii n, Mexican, I	n? (Specify Ye Puerto Rican,	etc.)		American Indian, Vhite, etc.	
36	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 📉 No If Yes, Give		1 🗌 Yes	2 💢 No	Specify:			Specify:	Black	
Ö	tural LER	p p		Year or Dates:	100 Deep	death Ha		tion.		40			
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or Itams 23a or 28a-f show ant. The Madical Exertition India Leunalified at	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Dece (Give	kind of w	ork done d use retired,	uring most o	of working	160.	Kind of Busine	ess/moustry	
12	with ene. then	Ĕ	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	Secre					C	overnme	n+	
	filed Hyginther		17. Father's Name (First, Middle, Last)		Becre	car y	-	18. Mother's	s Name (First,			111	
an	d be ental ked c	To Be	Robert Ruffin	ſr.				Vict	oria R	uffin			
Maryland	should Mand Mand	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Addres	s (Street a				y or Town, Sta	te, Zip Code)	
Ž	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show eny injury or other traumatic event. The Modical Extractive most be notified at 2000.		Roosevelt Picket	t Jr./Husband					1 Hiegh				
ē,	Hea Hea tem other		20a. Method of Disposition	20b. I	 Place of Dispo cemetery, crea	osition (Na	me of		Date	20c.	Location - City	or Town, State	
Baltimore,	ages ant of it: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Heiliovalilotti State					2/12/20	005 Su	itland.	Maryland	1
Ħ	artme ortan injur	1	21. Signature of Exparal Se Vita Lice					1			Funera		
Ba	Depa Impo eny i	. 12									Md. 20		
		_	23a Part1. Enter the disease, or com	plications that caused the dear								Approximate	
	DI		Immediate Cause (Final	one cause on each line.								Interval Betw Onset and D	veen Jeath
	Physician /Medical		disease or condition resulting in death)	a. Tatal Due to (or as a consec		Lac	1711	ytn	mia				
	Examiner			Due to (or as a consec	(uerice oi).								
· k	A 1864	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	juence of):								
	uted d ansit	E I	cause. Enter Underlying Cause (Disease or injury that initiated events										
Ć,	exec n an	Examiner	resulting in death) Last	Due to (or as a consec	juence of):								
760,	icate be executed physician and s the burial-transit	cal		d									
89	ifficat g phy as th				-								
Box	andin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1☐Live birth 2 ☐Feta		Tetasia -					23d. Date of	delivery	
0	dealt e atte d for	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of c		⊒Ectopic p ⊒ Other <i>(s</i>					Month	Day Y	'ear
Ö.	t the by th lache	Physiclan/Med	9 Unknown	9□ Unknown									
ري ح	The law requires that the death certifica ate has been signed by the attending phage 2 should be detached for use as the	by Р	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	nderlying	cause give	n in Part I.	23	e. Did tobacc	o use contribut	e to the cause of de	eath?
ğ	w require been sign									1 🗌 Yes	2 □ No 3 □	Probably 4 🗗	nknown
Records,	aw re	Completed							24	a. Was an	24b. Were	autopsy findings a	ivailable
	The law cate has page 2 t	E								autopsy performed? Yes 2 4	? deatl	to completion of ca h? Yes 2 ☐ No	use or
Vital		Bec	25. Was case referred to medical					26. Place o	of Death (Chec		10 13	2010	
	Phyaician: r this certifici ral director,	0	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	ER/Outpatier	nt 3 D	OA Othe	r: 4 🗆 Nurs	ing Home 5	☐ Residence	6 ☐Other (S	Specify)	
اه ر	ding Phyaician: After this certific funeral director.	T:U	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f	28c. Injury Work	at		scribe how in			
ō	Attending r death. actor: After	atlo	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	М		: ′es 2 □ No	0				
Division	i or Attendatiter deati	ij.	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str	reet, factor	ry, office			ation (Street		r Rural Route Numb) <i>01</i> ,
Ö	s afte	Certification;	7.3.114.11.114	ballaling, etc. (Gpace)	77				0.13	or rown, on	ato,		
	To the Hospital or At within 24 hours after of To the Funeral Diract completely filled in by		29a. Certifier 1 Certifying Ph	ysician: To the best of my known iner: On the basis of examination	wiedge, deat	h occurred	at the tim	e, date and	place, and due	to the cause	(s) and manne	r as stated.	
	the H in 24 the F plete	edical	one)	and manner stated.	andorin	vestigation	y op		occurred at th	e ume, date a	ing place, and	uue to the cause(s)	
	To To To I	Σ	29b. Signature and title of certifier	1.12		29	c. License	number		29d. [onth, Day, Year)	
			> SIVI	MD			D5664	3			2/1/	2005	
	5	1	30. Name and address of person who										
			Dr. Sandra Banks					Cheve	erly, M	D 2078	5		
	Sta Registi		31. Date filed (Month, Day, Year)	32. Pagistrar's Sign	H A	medi	,						
	1666		9 9 32 11 8 71	1111 INTERNAL .	~ 476								

			1 - For State Registrar	State of M	larylar		artment of				giene Reg. No	\mathbf{U}	03718
I	Physici	an	1. Decedent's Name (First, Middle, Last							2. Date of De Month	ath Day	y Yea	3. Time of Death
	/Medic	cal	ALEXANDER MacL 4a. Facility Name (If not institution, give			CHAZKA	4b. City, Town	ar Location	of Dooth	Februar		,	4:30A M
	Examin	ner	Gilchrist Center	street and number)		TOW		or Death		4C.	County of De	timore
ī	Funeral		Social Security Number 6. Se		ge (In yrs.	last birthday)	If Under 1 Ye	ar If Under	24 Hrs. Min.	8. Date of Bir	th Vear)		Birthplace (State or Foreign
	Director			XM 2□F	77	Yrs.	Months Da	ys Hours	Milli.	8. Date of Bir (Month, Da June 16,	1927	⁷ Ne	w Jersey
	land bw		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	Mary Me-f sh	tor	Maryland Baltimor	e	Owi	ngs Mi	lls						1 ☐ Yes 2√ No
	death with the Maryland ms 23e or 28e-f show	Director	10e. Street and Number		-1		10f. Zip Cod				10g. Cit	izen of What	
	s 23e		P 0 Box 313	40.141 5				1117				USA	
_	fter de r Item iirer	Funeral	11. Marital Status 1 Never Married Married	12. Was Decedent Armed Forces 122 Yes 2	No WW	' ' '	Was Decedent of f Yes, specify C	uban, Mexica	igin? (Spe n, Puerto l	Rican, etc.)		Black, W	·
3-003e	rel', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1⊡ Yes 🤾 💢	No Specify.	:			Specify:	White
2-0	be filed within 72 hours after ital Hygiene. Id other then "neturel", or Ite event, It e Medical Extrolite	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)		16a. Deced	dent's Usual Oc kind of work do OO NOT use re	cupation ne during mos	st of worki	ng	16b. K	ind of Busine	ss/Industry
Z	within ene. then	duc	Elementary/Secondary (0-12)	College (1-4or 5+	5+)		gineer	irea)			M	anufac	tunina
<u> </u>	illed Hygi other	Be Co	17. Father's Name (First, Middle, Last)				grneer	18. Moth	er's Name	(First, Middle,			ruring
/land	should be and Menta a marked umetic ev	To B	Julius Albert Proc	hazka				Jea	an Ma	cLennar	7		
Jan	iges 1 and 2 should be filled within 72 hours after death with the Maryla. It of Health and Mental Hygiene. If item 27 is marked other then "neturel", or Items 23e or 28e-f show or other treumetic event. It a Modical Examiner mast be naillised at		19a. Informant's Name/Relationship (T)	-	11:6-		ng Address (Str						, Zip Code)
a) (a)	1 and Healti em 27		Frances D.H. Proch	d∠Kd	20b. F	Place of Dispo	OX 313 (sition (Name of			s Mary			or Town, State
	Pages nent of int: If its iry or o		1 Burial 2XXCremation 3 6		€		natory or other p nt Ceme	, ,	2/4/0	5			, Maryland
baltimor	permit. Pages Department of I Importent: If ite any injury or of once.		21 ignature of Funeral and ide Licens	1./	1						defel	d Funera	al Home Inc.
<u> </u>	88 58		Noune Degra	1 Cha	Res							e, Mary	land 21212
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	e cause on each	line.								Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Chron	1001	GSHLUC	avi p	Ulmon	ary	Cister	26		YEAVES
	Examiner			Due to tot as	s a consec	querice (ii).			(
/	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	s a conseq	quence of):							
V	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	s a consec	uence of):							
00/0	icate be executed physician and the burial-transit	dicai E	l	d		,							
Ď	The law requires that the death certificate be the has been signed by the attending physicial agge 2 should be detached for use as the but	0	IF FEMALE:	v									
200	death certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Feta	al death 3 □	Ectopic pregna				- 54 3	23d. Date of c	telivery Day Year
	the day	ysic	1 Yes 2 No	4∏Pregnant a 9∏Unknown	at time of c	death 5∟	Other (specify,	·					24,
Ţ.	uires that the de signed by the a ld be detached f	by Ph	Part II. Other significant conditions co	ntributing to death I	but not res	sulting in the ur	nderlying cause	given in Part I	l.	23e. Did to	obacco u	se contribute	to the cause of death?
cords,	w require: been sig should b	ed b								1 (1)	res 21	□No 3□	Probably 4 Unknown
ט ט	law requias been 2 should	Completed								24a. Was	sy	prior to	autopsy findings available o completion of cause of
										perfo	rmed? 2 X No	death'	? es 2 No
\ \ \	sicier certif irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpati	iont 2	ER/Outpatien	t 3 DOA	Othor		_(Check only only only only only only only only		Softher (Sp	and the same
5	ding Physicien: The Ih. After this certificate he funeral director, page	\vdash	27. Manner of Death	28a. Date of Inj	ury	28b. Time of Injury	28c. lr	njury at Vork?		28d. Describe		1	pecily) VIOSPICY
IVISION	Attendin death. ctor: Af y the fur	catio	17 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-,	,u.y		□Yes 2□	No				
2	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	ijury - At h tc. (Specii	ome, farm, str fy)	eet, factory, office	Ce Ce	2	28f. Location (5 City or Tox			Rural Route Number,
_	To the Hospital or Attending Physicien: within 24 hours after deals to the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier Certifying Phy	sician: To the best	of my kno	owledge, death	occurred at the	time, date ar	nd place, a	and due to the	cause(s)	and manner	as stated.
	the Ho in 24 I the Fu ipletely	edical	(Check only 2 Medical Exami	ner: On the basis of and manner s	of examina	ation and/or inv	estigation, in m	y opinion, dea	ath occurre	ed at the time,	date and	place, and d	ue to the cause(s)
	with To 1	Σ	29b. Signature and title of certifier					ense number	2				nth, Day, Year)
	~		30. Name and address of person who co	mpleted cause of	death (Iter	n 23a) (Type	Print) 4	0 70	ر 		- Cls	yar y	3 2005
	X		AARON J. CHAR	rs m	Go	Q N	-Charle	5 St	Bal	timore	no	212	04
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist									
	riegisti	पा	EED 0 8 2005	Bleed . Le .	10	110	2.50						

Registrar DHMH 17 Rev 1/2001

State

FFR 0 8 2005

Division of Vital Records, P.O. Box 68760,

ss of person who completed cause of death (Item 23a) (Type, Print)

		For State Registrar	ate of Maryland	l / Depa <i>Cei</i>	artment of H tificate of L	ealth and Death	Mental Hygie		03720
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Louise A. Pu	gh				2. Date of Death Month February	Day Yeer 02, 2005	D 14
Examin	er	4a. Facility Name (If not institution, give stree Ivy Hall, 1300 Wind	lass Drive		4b. City, Town, or Middle R		th	4c. County of Dec	ath ore
Funeral Director		5. Social Security Number 213-30-8854 6. Sex 1 ☐ M Usual Residence of Decedent	7. Age (In yrs. la 2017 F 90	Yrs.	Months Days	Hours Min		9 Bi 1914 Ma	rthplace (State or Foreign ountry) ryland
e Maryland la-f show	ctor	MD Baltimore		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2☐ No
be filed within 72 hours after death with the Maryland ital Hygiene. bd other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be ruillied at	d by Funeral Director	1 Never Married 2 Married 1	Vas Decedent Ever in U.S immed Forces? □Yes. 2 ☑ No Yes, Give 'ear or Dates:		10f. Zip Code 21220 Vas Decedent of Hi Yes, specify Cuba	Specify:	Uni	14. Race - Am Black, Wh	es of Ameri
within 72 h ene. than "natu he Wedical	Completed			(Give life. I	lent's Usual Occupa kind of work done o DO NOT use retired, se Wife	uring most of we	orking	b. Kind of Busines:)wn Home	s/Industry
hould be filed of Mental Hygist marked other matic event,	To Be Co	12 17. Father's Name (First, Middle, Last) Charles A. Roui	ller			18. Mother's Na	me (First, Middle, Mai		(Unknown)
permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 Is marke any injury or other traumatic ADGs.		19a. Informant's Name/Relationship (Type, Informant's Name/Relationship (Type, Information July 1998) 20a. Method of Disposition 1 ⊕ Burial 2 □ Cremation 3 □ Remo 1 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Son 20b. Place control wood	207 Mace of Dispo metery, cren dlawn	fiddle Way sition (Name of natory or other place Cemetery . Name and Addres	Apt. 3	Date 200 08/05 Wo	River, M c. Location - City o odlawn, Funeral	aryland 212 Town, State Maryland Directors,
Physician /Medical Examiner		23a. Party. Enter the disease, or complication shock, or heart failure. List only one car	ons that caused the death. use on each line. Here to (or as a consequence)	Do not ent	er the mode of dying	, such as cardia			Approximate Interval Between
cate be executed obysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a conseque	,,,,,					
death certifi e attending p id for use as	Physiclan/Med	in the past 12 months?	f yes, outcome of pregnan □Live birth 2 □ Fetal o □ Pregnant at time of dea □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	l blivery Day Year
signe d be d	by	Part II. Other significant conditions contribu	iting to death but not resul	ting in the ur	nderlying cause give	n in Part I.	23e. Did tobac 1 ☐ Yes		o the cause of death?
The law ate has b page 2 sl	Completed						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of s 2 No
Attending Physician: The death. ector: After this certificate by the funeral director, pag	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Matural 5 Pending investigation	1 Inpatient 2 E	R/Outpatien 28b. Time of Injury	28c. Injury Work	at Nursing	ath (Check only one) Home 5 Residence 28d. Describe how		ecify)
tal or Attendi s after death. al Director: A ed in by the fu	Certification:	2 Could not be	Be. Place of Injury - At hon building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (Stree City or Town, S		lural Route Number,
To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	ledical	(Check only 2 Medicel Examiner:	n: To the best of my know On the basis of examination and manner stated.	on and/or inv	estigation, in my op	inion, death occ	urred at the time, date	and place, and du	e to the cause(s)
with	M	29b. Signature and title of certifier	eted cause of death (Item:		D43	number 3725	29d.	Date signed (Mon	th, Day, Year)
A		30. Name and address of person who comple	eted cause of death (Item:	23a) (Type,	Print) Back	Rive	Neele	KU B	altimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** DeVaughn 2005 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA Healthcare ear If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12 DL 1954 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Funeral Months Days Min 1**X**M 2□ F 213-62-2345 MD Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or flems 23a or 28e-f shov Examiner must be notified at MD 13a Himore Completed by Funeral Director 1 TxYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Street 21229 39 N. Morieil 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 SENo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 25 No Specify: Specify: BLACK 3 Widowed 4 □ Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Factory Facton 12th arade other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be fill Health and Mental Hi tem 27 is marked oth Be Sarah Perlie Parker Blue ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Sarah Parker/Mother 39 N. Morrey Street Baltimore MD 21229 item 27 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō 1

Burial 2 □ Cremation 3 □ Removal from State = 5 Department of Important: If any injury or once. 02.05.05 Baltimore, MT. ZION * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu e f Funeral Service Licenses 22. Name and Address of Facility Vaughn C. Greene Funeral Services Vary SIST Baltimore National Pike Baltimore ND 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician ther osc 10 years disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, flading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se's consequence offi Physician/Medical Examiner use as the burial-transit Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No director, page 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ➤ FR/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending death, investigation 1 ☐ Yes 2 ☐ No after death Director: 3 🗌 Suicide 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled i 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title of certif

State

sevandhn

Registrar

d cause of death (Item 23a) (Type, Print)

O M O S

32. Registrar's Signature

who completed cause

17 0027313

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** John J. Paszek February 4 2005 200 4:20 pm /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Care Center Parkville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. October 31, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 80 Yrs Director 212-20-0373 Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location itam 27 is marked other than "natural", or Itams 23a or 28a-f show othar traumatic event, the Modical Examinar must be notified at 10d. Inside City Limits Completed by Funeral Director MD Baltimore Parkville 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Blvd #1208 21234-5721 U.S.A. 12. Was Decedent Ever in U.S. Asyled Forces? VOYYes 2 □ No WW II If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 sho lid be filed within 72 Department of Health and Nental Hygir ne. Important: If item 27 is marked other than "na any injury or other traumatic event, it. Mudic. Elementary/Secondary (0-12) College (1-4or 5+) Physicist U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leon Paszek Theophilia Siwinski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8810 Walther Blvd #1208, Baltimore, MD 21234-5721 Dr. Stanley M. Kotula-brother in law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corporation 2/8/05 `4 □ Donation 5 □ Other (Specify) Towson, MD 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician End Stage
Due to (or as a consequence of): disease or condition resulting in death) Dementia /Medical Examiner vascular disease cerebral Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 hknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? 1 🗆 Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Mursing Home 5 | Residence 6 | Other (Specify) ပ 1 ☐ Yes 2X No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) monico D58646 February 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800 walther Boulevard Paskullla monias 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

PM 5-00809 Sheree Ruble

e I	Ruble		1 - For Amend Item Registrar G840 2-24	1&5 State of 185 Per 18	Marylar lewith &	d/Depa Inpend Ce	artmeni rtificate	tot H 23a e of L	lealth a Death	and M	lental Hy	giene 0	05	03723
	Physici	an	Decedent's Name (First, Middle	o, Last)							2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic		Sherree Lee 4a. Facility Name (If not institution		nhael		4b Ciby	Tours or	Location of	of Dooth	Januar		2005	09:07 A ^M
	Examin	er	508 Munroe Circ	-	noer)				Burn				nne Ar	undel
	Funeral		5.2°4 S8 W 9692	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir	th		place (State or Foreign
	Director		224 88 9692 Usual Residence of Decedent	1□ M 2√ F	4.	3 Yrs.	Months	Days	Hours	Min.	(Month, Da Aug 14,	1961	VA	ntry)
	land ow		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						1	I Od. Inside City Limits
	Mary -4 sh	ţo	MD Anne	Arunde1	G:	len Bui	rnie							1 □Yes 2 No
	n 286	irec	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Cour	ntry?
	th wit	aiD	508 Munroe Cir	rc1e				210	61			U	.S.A.	
92	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 ie marked other than "natural", or Itema 23a or 28e-f show spry injury or other traumatic event, Itte Marified Examinat must be raulified at ODGe.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marr	Armed Fo ied 1 ☐ Yes If Yes, Giv	² XNo		Was Deced If Yes, spec		ispanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)	- 14. F B	lace - Americ lack, White, cify:	etc.
21215-0036	tural'	d be	3 Widowed 4 Divorced	Year or D	ates: 	16a Dece	dent's Usua	LOccupa	ation			16b Kind of	Business/In	vhite
<u>.</u>	in 72 in ma	Completed	(Specify only highes	t grade completed)	45-3	(Give	kind of wor DO NOT us	k done d e retired	during mos	t of worki	ing	TOD. KING OF	Dusinessym	austry
212	y with	Elo	Elementary/Secondary (0-12) 12	College (1	-4or 5+)		ab1ed					Neve	r Work	ced
פַ	e filec othe vent,	Be C	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name	(First, Middle,	Maiden Sum	ame)	
Maryland	uid b Menta Menta rrked	ToE	Harvey Eugene	Smith					Jan	ice	Shir1ey	Smith		
lan,	2 sho and le ma		19a. Informant's Name/Relations	hip (Type, Print)			_				I Route Numbe			Code)
<u>√</u>	end ealth m 27 her tr	11	Mr. Samuel Rub	Le / husba					rcle,		n Burni			
Baltimore,	it of H		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation		State	Place of Dispo cemetery, crer	natory or of	her place			ate	20c. Locatio		
Ë	t. Pa rtmen rtent: njury		4 □ Donation 5 □ Other (S		Che						4,2005			
Bal	Depa Impo any ir once		21. Signature of Funeral Service	ly ma	319			nd A	Avenu	e S.	ngleton W., Gle	n Burn		
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that conly one cause on e	ach line.	h. Do not ent	er the mode	e of dying	g, such as	cardiac c	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		or as a conseq	uence of):					,			
	pd slt	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq	uence of):								
oʻ	be executed sician and burial-translt	Examiner	that initiated events resulting in death) Last	c	or as a conseq	uence of):								
68760,	ificate be g physici as the bu	edicai		d										
.O. Box	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown		irth 2 ☐ Feta ant at time of d	Ideath 3□	Ectopic pre Other (spe						Date of delive Month	ery Day Year
ds, P	uires that the de signed by the a d be detached f	by	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the u	nderlying ca	iuse give	en in Part I.		23e. Did to			ne cause of death?
Records,	ie law require has been sig ge 2 should b	Completed									24a. Was		prior to cor death?	psy findings available impletion of cause of
a F	Phyaician: The la r this certificate had ral director, page 2											2 □ No		2 □ No
<u>=</u>	Phyaiclan: r this certifica ral director,	Be c	25. Was case referred to medical examiner?	Hospital:		55/5:		Othe			(Check only o			CODE
ō	Phyarr this aral di	.: To	1 XX es 2 ☐ No 27. Manner of Death	28a, Date of	of Injury	ER/Outpatien 28b Time of		Bc. Injury Work	4 🗀 140		ne 5 Resid			// SCENE
on	th. th. : Afte	tion	1 Natural 5 Pendin	g 1-31 ¹ co found		9:00 Time of found	\mathbf{a}^{M}		:? ∕es 2 7∑ 1	No S	ubject	hanged	self	
Division of Vital	To the Hospitel or Attending Pi within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Certification;	3 Suicide 6 Could r 4 Homicide determ	not be ined 28e. Place building	of Injury - At hong, etc. (Specify	ome, farm, str		, office		2	28f. Location /S	Street and Nut m, State) 50	nber or Rura 8 Mun r	Route Number,
	To the Hospitel within 24 hours a To the Funeral completely filled		(Check only 2XXMedical	g Physician: To the Examiner: On the ba	best of my kno	wledge, death	n occurred a	at the tim	e, date and pinion, deat	d place, a	and due to the	cause(s) and	manner as st	ated.
	thin 2 the or the	Medical	one) 29b. Signature and title of certifier	and manr	ner Stated.		29c.	License	number			29d. Date sign	ned (Month.)	Day, Year)
	2 × × × ×			1 ml.	1	_								
			30. Name and address of person	no completed caus	e of death (Item	n 23a) (Type		.C.M	1. Ľ.			Februa	iry UI	, 200)
			JACK M.	Tipy No	17	111 P		tree	t, Ba	altin	nore, Ma	aryland	1 2120	1
	Sta Registr		31. Date filed (Month, Page Year)		egistrar's Signa	A A	and o							

			for State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of H rtificate of L			ene 2005	03724
I	Physic		1. Decedent's Name (First, Middle, Las Deborah R. Rowle	,		•		2. Date of Death	y ^{Da} y, 2005	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give Upper Chesapeake		Genter	4b. City, Town, or Bel A:	Location of Death		4c. County of Death	
	Funeral Director		5. Social Security Number 6. S 579-62-9389 Usual Residence of Decedent		(In yrs. last birthday) 9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Sept. 23	rear) Cou	place (State or Foreign intry) nnsylvania
.0036	ital Hygiene. Ital Hygiene. Ital Hygiene. evant, the Medical Evan tractinist be notified at	ai Director	Md. Harfor 10e. Street and Number 4944 Clermont Mi	·d	10c. City, Town or Lo	11e	1132	100	g. Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☐ No X ntry?
21215-0036	atural, or items :	ted by Funeral	11. Marital Status 1 □ Never Married 2⊠ Married 3 □ Widowed 4 □ Divorced 15. Decedent's Ed	12. Was Decedent Evarmed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No dent's Usual Occupa	Specify:		14. Race - Ameri Black, White, Specify: wh	ite
	other than "n	Completed	(Specify only highest gra	College (1-4or 5+	(Give	kind of work done d DO NOT use retired)	uring most of work	ing	own home	dusity
Z E	nd Mental H markad ott	To Be	17. Father's Name (First, Middle, Last) Aaron W. Stover 19a. Informant's Name/Relationship (7	Type Print)	10h Maili		Katheri	ne Mille:	,	
re, Mi	Health a tam 27 is othar trac		John Rowles/husb	and	4944 20b. Place of Dispo	Clermont	Mill Roa	d, Pyles	ville, Md. c. Location - City or To	21132
Baltimore,	Department of Important: If it any injury or o		1 Burial 2 Cremation 3 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen	see	Con-O-Lit	te Cremato Name and Address Schimunek	ory 2/05/ s of Facility Funeral	Home of 1	chaefferst Bel Air, I	nc
Acuted	physician and withe burial-transit the burial-transit	i Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Acute Due to (or as a						Approximate Interval Between Onset and Death
.O. Box 66/60;	been signed by the attending physic should be detached for use as the t	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopuls? 1 □ Yes 2 □ No 9 □ Unknown	d	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive	9ry Day Year
ouires that	been signed be should be deta	by P	Part II. Other significant conditions co	ntributing to death but	not resulting in the ur	nderlying cause giver	n in Part I.	23e. Did tobac	cco use contribute to the	ne cause of death?
The law requ	is certificate has be director, page 2 sho	Completed					·	24a. Was an autopsy performed 1 Yes 2	prior to cor death?	psy findings available mpletion of cause of
anding Physician	within 24 hours after death. To tha Funeral Diractor: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	ertification; To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y	2 (LER/Outpatien 28b. Time of Injury	t 3 DOA Other 28c. Injury a Work?	at 2		e 6 □Other (Specify injury occurred	')
Spital or Att	ours after de neral Diracto filled in by t	O	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.				City or Town, S		
To tha Hos	within 24 hours a To tha Funeral I completely filled	Medical	(Check only one) 2 Medical Examination Medical Examination Medical Examination (Check only one) 29b. Signature and title of certifier	and manner state	vamination and/or inv	estigation, in my opii	nion, death occurre	d at the time, date	and place, and due to Date signed (Month, I	the cause(s) Day, Year)
	6		30. Name and address of person who co	Dompleted cause of dea	th (Item 23a) (Type, I	D 3	5012	F	ebruary	3,2005
	Sta Registra		J. Kedin Lyrica 31. Date filed (Month, Day, Year) FFR 0 8 2005	A Registrar's	s Signature	W	(P	BelA	it, Md	. 2/0/4

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year THERRY FEBRUARY 7005 1:44 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death JOHAS HORKING BAYVIEW MEDICAL CENTER BALTIMORE BALTIMORE Social Security Number , 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, **Funeral** Birthplace (State or Foreign Country) 7-2858 1 M 2 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show treumetic event, the Medical Examiner must be notified at Be Completed by Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SP Items 23a 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 NO Baltimore, Maryland 21215-0036 ō 1□ Yes 2□ No Specify: 3 ☐ Widowed 4 ☐ Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I WOOD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. e) permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other treu once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 Removal from State * 4 □Donation 5 □ Other (Specify) moreland 22. Name and Address of Facility EVANS 21. Sign Juya of Funer **→**ice Licensee Chapel RD Parkville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MYOCARDIAL disease or condition resulting in death) INFARCTION /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate causa. Example or injury that initiated events Examiner Due to (or as a consequence of) Hospitel or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month 4☐ Pregnant at time of death 5 Other (specify) P.0. 9□ Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ HYPERTENSION Completed 4 Unknown certificate has been si rector, page 2 should 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 2007 2000 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2X No Cther: 2 1X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28b. Time of Certification: 28c, Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funerel D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KES-000 TEBRUARY 7 ZOOS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. VENERTECH MURTHY, 4940 EASTERN AVENUE, BAUTIMORE, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

				1 - For State Registrar		State	of Mai	ryland				ealth and Death	Mental H		201)5	037	26
		q		Decedent's Name (First, Midd	le, Last,)							2. Date of				3. Time of I	Death
		Physici /Medio		Wilson Lero		Rassa							Feb.		Day	Year 2 CO 5	01.35	SCM
		Examir	ier	4a. Facility Name (If not institution						4b. City,	Town, or	Location of De	ath		4c. County		1	
				5+ Agnes 5. Social Security Number	6. Sex	25pit		(In use les	4 5 int	152	3 17	If Under 24 Hi				N/A		
		Funeral Director		219-30-9787		0 M 2□F	7. Age	(In yrs. Ias 70	Yrs.	Months		Hours Mi		Birth Day, Yea 1 1 (ar)	9. Birth	place (State or intry)	Foreign
				Usual Residence of Decedent				70					OCL.	Ι, Ι	934	11	aryland	
		show	_	10a. State 10b. Count				10c. City,	Town or Lo			-					10d. Inside City	Limits
		or 28a-f	Director	Maryland	N/A	<u> </u>			Balt	imore	9						1 Yes	2 🗌 No
		with t	Dir	10e. Street and Number 1913 Christian	C+					10f. Zip	Code 212	222		10g.	Citizen of 1		intry?	
		ours after death with the Maryla ral', or Items 23a or 28a-f shov Exartinal must be notitled at	Funeral	11, Marital Status		12. Was Dec	edent Ev	er in U.S.	13. V	Vas Decer			Specify Vec or	No-	U.S		ican Indian.	
	9	after deal		1 ☐ Never Married 2 ﷺ Ma		Armed F	orces?		if		47		Specify Yes or roto Rican, etc.)	40-	Blac	ck, White	, etc.	
	93	ours ours	d by	3 ☐ Widowed 4 ☐ Divorce	t	If Yes, G Year or D	Dates: 19	957 – 5	9 1	☐ Yes	2 No	Specify:			Specify	v: Wh	ite	
	5-	"natural",	Completed	15. Decede (Specify only highe	nt's Edu	cation e completed))		16a. Deced (Give	ent's Usua kind of wo	al Occupa rk done d	tion uning most of w	orking	16b.	Kind of B	usiness/lr	ndustry	
	12	withir ene. than	дш	Elementary/Secondary (0-12)		College (1-4or 5+)			ю мот из uck I				Car	nitol	A 11+	o Parts	ı
	9	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, I've Medical Exertains must be notified at	CC	17. Father's Name (First, Middle	Last)					uch 1			ame (First, Midd				o rai ts	
	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: if item 27 is marked other than any njury or other traumatic event. Ite Magnes.	To Be	Paul Rassa		Sr.						Inez	Rassa			,		
	Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relation Shirley J. Ras		рө, Print) (Wife))		19b. Mailin	Address Chri	(Street a	nd Number or F	Rumal Route Num et, Balt	i mon	or Town,	State, Zi	Code)	23
	ē,	Heall tem 2	20	20a. Method of Disposition		("110,		20b. Plac	e of Dispos	ition (Nan	ne of	- 1	Date Date	+			own, State	23
	ē	Pages ent of ht: If Ii		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (lemoval from	State	cem	netery, crem 1awn	atory or o	ther place	02-0	07-05				aryland	
. 2	alti	pertm portar y injui		21. Signature of Funeral Service		99		1.	22.	Name an	d Addres	s of Facility _						
1	ñ	Per E		Jane C	89	cen	nn	//()	Mc 23	Cully 7 Eas	r-Pol	yniak H	Tuneral Avenue,	Home	P.A		21225 Marylan	d
V				23a. P. rt1. Enter the disease, of hock, or heart failure. Lis	r compli	cation at one cause on e	caused the	e death.	Do not ente	r the mod	e of dying	, such as cardia	c or respiratory	arrest,	CIMO		Approximate Interval Between	
		Physician		Inmediate Cause (Final Isease or condition		M.	Y Dr	ordi	101	TA	face	tion					Onset and De	eath
		/Medical Examiner		resulting in death)		Due to		consequer			. 0, .	(10)					[1734	
			-	Sequentially list conditions,	ь	Due to	(orașa	S S	ace off:								SOUV	5
		uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause that Industries Cause (Disease or injury that initiated events	<	0.010	(0, 00 0,	Joniseque	100 01).									
	ó	exection and rial-tra	Еха	resulting in death) Last	c	Due to	(or as a c	consequen	nce of):			<u> </u>						
	8760,	icate be executed physician and s the burial-transit	dical			l												
	9	ntifica ng ph	Med	IF FEMALE:	_	-												
	30	eath certific ettending p for use as	lan/I	23b. Was decedent pregnant	23		pirth 2	Fetal de	eath 3 🗆	Ectopic pr	egnancy					e of deliv	*	
	P.O. Box	The law requires that the death certificate be executed the has been signed by the ettending physician and hage 2 should be detached for use as the burial-transi	Physician/Me	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		4□Pregr 9□Unkn		ne of deat	h 5□	Other (spe	ecify)				Mo	nin	Day Ye	ar
		that the by detac		Part II. Other significant conditi	ons con	tributing to d	eath but	not resultir	ng in the un	derlying ca	ausa giva	n in Part I.	23e. Dio	tobacco	use contr	ribute to ti	he cause of dea	ath?
1	rds,	w requires been sign should be	Completed by	Congestive	1	Fleunt	*	=ail	ute.] Yes			pabiy 4 ∑ Un	
C	000	aw re	plet	,									24a. Wa		24b. V	Vere auto	psy findings av	ailable
1520	Vital Record		Com				-					·		opsy formed?	0	rior to co leath?	psy findings av mpletion of cau 28 No	ise of
-	/ita	Physician; The this certificate ral director, pag	Be	25. Was case referred to medica examiner?	1							26. Place of De	ath (Check only		10 1	U 185	200 140	
3	of \	S 0 T	2	1 ☐ Yes 2 ☐ No	Н		Inpatient		/Outpatient		-	4 🗆 Nursing	Home 5 ☐ Re	sidence	6 □Othe	er (Specif	y)	
3		ing ineth	lon	27. Manner of Death 1- Watural 5 □ Pendi		28a. Date (Mon	of Injury th, Day Y	'ear) 28	b. Time of Injury		Bc. Injury Work		28d. Describe	how in	ury occurr	ed		
0550,	Division	Attanding r death. actor: After by the funer	ficat	2 Accident investi 3 Suicide 6 Could	not be	28e. Place	of Injury	- At home	a, farm, stre	M et factory	- J	es 2 No	28f Location	(Street :	and Numbi	ar or Rum	l Route Numbe	
20	Ö	apital or At ours after o naral Dirac filled in by	Certification:	4 - Homicide determ	ined	buildi	ing, etc. ((Specify)	,,	ot, luctory	OIIICO		City or T	own, Sta	te)	פוטרו וט ופ	i noute Numbe	er,
>		To the Hospital or Attandi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu	edical	29a. Certifier (Check only one) Check only one)	ng Phys Examin	ier: On the p	best of r asis of ex ner state	camination	dge, death and/or inve	occurred a	at the time in my opi	, date and plac nion, death occ	e, and due to the	e cause(, date a	s) and ma nd place, a	nner as s	tated. the cause(s)	
		within To t	Σ	29b. Signature and title of certifie	0					29c.	License	number		29d. D	ate signed	(Month,	Day, Year)	
	,	. \		Die	5	-2		>			P16	6979		Fe	bal	SCAN	, 03, 20	205
	11)+,		30. Name and address of person	\wedge	1				rint)			Λ 1.	,			2122	
		Sta	te	31. Date filed (Month, Day, Year,	DG	S CGC	legistrar's	Signature	100	cato		Ave,	15al+	imo	re	MY	2122	9_
		Registr		FEB 0 8 2	2005	Bea	de	K	Ann	E								

			1 - State of Maryland / Dep	partment of Health and Mertificate of Death	lental Hygie	THE CO. CO. CO.	13727
			Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physici /Medio		Anna L I	Ray	February	Day Year 7 1 2005	2:49 A ^M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Frederick Memorial Hospital	Frederick		Frederic	k
	Funeral Director		5. Social Security Number 215-18-1370 6. Sex 1 7. Age (In yrs. last birthday 81 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day Ye March 10,	9. Birthpla 9. Bir	ce (State or Foreign y) 1and
	pus *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or 1	ocation	-	100	d. Inside City Limits
	f sho	ō	Maryland Frederick Frederi				1 ☐ Yes 2 ☐ No
	288-1	Director	10e. Street and Number	10f. Zip Code	100	. Citizen of What Countr	
	with Sa or		7914 Wit-Mere Court	21702		J.S.A.	y :
	ne 23	era	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Spe		14. Race - American	n Indian.
36	be filed within 72 hours after death with the Maryland tal Hygiene. dother then "neturel", or iteme 23a or 28a-f show event, the Madical Examinar must be notified at	by Funeral	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☒ Widowed 4 ☐ Divorced Year or Dates:	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify:	Rican, etc.)	Black, White, et Specify: White	c.
0-10	2 hou	Completed by	15. Decedent's Education 16a. Dec	edent's Usual Occupation	161	b. Kind of Business/Indu	stry
215	hin 7 9n "n Mad	ple		re kind of work done during most of working DO NOT use retired)			
7	e filed within al Hygiene. other then ' vent, the Ma	No.	11 As	ssembly Line Worker		Manufacturi	ng
nd	be filed ital Hygie of other event, u	Be (17. Father's Name (First, Middle, Last)		(First, Middle, Mai		
yla	2 should be and Mental le marked o reumatic eve	၉	Herbert L. Derry		h L. Hawr		
, Maryland 21215-0036	alth and 27 le m			iling Address <i>(Street and Number or Rura</i>) Rocky Springs Roa			
ore	~ ~ .			ematory or other place)		c. Location - City or Town	n, State
Ĕ	Pages ment of I ent: If its ury or o		'4 □Donation 5 □Other (Specify) Mount OL	ivet Cemetery Feb. 4,	2005 F	Trederick, N	MD
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licensee M00255	22. Name and Address of Facility Keeney and Basfor 106 East Church St	d PA Fune	eral Home	1701
	100		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac o	or respiratory arrest,	, i	Approximate nterval Between
	Pnysician		Immediate Cause (Final disease or condition	Cordio Vascalas) Dian	99	Onset and Death
	/Medical		resulting in death) a. One to (or as a consequence of):		<u></u>		7
н	Examiner		Sequentially list conditions b.				
	₽ ∺	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	icate be executed physician and s the burial-transit	cam	that initiated events				
8760,	oe ex	E	Due to (or as a consequence of):				
87	cate b	dical	d				
9 X	the death certificate be executed y the attending physician and sched for use as the burial-transit	0	IF FEMALE: 23c. If yes, outcome of pregnancy			and Date of delivery	
Вох	atten for u	Physiclan/M	in the past \$2 methods? 1 Live birth 2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month D	ay Year
o.	t the de by the a tached	issi	1 □Yes 2X No 9 □ Unknown				
<u>α</u>	that ned by deta		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the	cause of death?
ds,	uires sign	d by	Minister Mellitas		1 🗆 Yes	2 No 3 Probab	oly 4 Unknown
Records,	The faw requires that ite has been signed b page 2 should be deta	Completed			24a. Was an	24b. Were autops	y findings available
Re	The fav	Juc			autopsy performed		y findings available pletion of cause of
Vital		a)	25. Was case referred to medical	26. Place of Death	(Check only one)	No 1 ☐ Yes 2	No
>	Physiclen: this certific ral director,	0.0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Other		e 6 Other (Specify)	
1 of	g Ph ter th	T:U	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 2	28d. Describe how i		
0	Attending r death. ector: After by the fune	atlo	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	M 1 Yes 2 No			
Division	al or Attending P safter death. ! Director: After d in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural F State)	Route Number,
	tal or rs afte el Dir	Cer					
	To the Hospital or within 24 hours after To the Funerel Dire completely filled in b	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea continuous and manner stated.	th occurred at the time, date and place, a mestigation, in my opinion, death occurred	and due to the caus ed at the time, date	e(s) and manner as stat and place, and due to the	ed. ne cause(s)
	To t To tl	Σ	29b. Signature and title of pertifier	29c. License number	29d.	Date signed (Month, Da	ny, Year)
•	1		XMM L. Karmen	D-1397/		2/1/05	
6			30. Name and address of person who completed cause of death (Item 23a) (Type Robert L. Kaufmann, M.D., 300 Wes	e.Print) t Ninth Street, Fre	ederick,	MD 21701	
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	E .			

State of Maryland / Department of Health and Mental Hygier 0 0 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5.10 AM Lillet Ε. Reid 02 OF 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Deeth Examiner BALTIMORE N/A SAMARITAN HOSPITAL GOOD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Yeer) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 M 2 F Yrs. 042-42-4874 84 Director February 26, 1920 Jamaica Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r then "natural", or Items 23a or 28a-f ehow the Medical Examinar must be notified at MD Baltimore Baltimore 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3651 Campfield Road 21207 United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🂢 No Specify: Specify: **Black** δ 3 Midowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nursing 2+Geriatric Nurse if Health and Mental Hygis Item 27 Is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Abraham Harris Johanna Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 le any injury or other trau once. Heather Valentine (Daughter) 6012 Worthwood Road, Baltimore, Maryland 21212 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Baltimore-Washington Crem 02/20/05 * 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors 8728 Liberty Road, Randallstown, Md. 21133-4784 Peril. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 24 hrs SEPTIC SHOCK /Medical Due to (or as a consequence of) Examiner 72 hrs PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physicien the use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ò in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 Tes 2 NO 3 ☐ Probably 4 ☐ Unknown RENAL FAILURE Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ Ho 2 W 100 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 2 1 Yes 2 No 1 Impatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) uneral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be 3 🗍 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after de Funeral Direct 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Khath MD RES OUD 2 5 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601, LOCH RAVEN BOULEVARD BALTIMORE 21239 MATHEWS ZEEBA 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 08 2005

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of ertificate of			giene 0 (05 03729
I	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time of Death
	/Media	al	Mahmonir Rashidi 4a. Facility Name (If not institution, give s			45 Ch. Taur	or Location of Death	Februa:	4c. County o)5 11:58 A ^M
	Examin	er	Suburban Hospital	street and number)		Bethesd		1	,	gomery
	Funeral		Social Security Number 6. Sex		e (In yrs. last birthday) If Under 1 Yea Months Days		8. Date of Bir (Month, Da		9. Birthplace (State or Foreign Country)
	Director		210-27-9000]M 2\$2∫F	89 Yrs.	Months Days	S Hours Mill.	January	1,1916	Iran
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	Mary 9-f sh	tor	Maryland Montgomery	У	Rockville	9				1 □ Yes 2 図 No
	or 28	Olrec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wi	nat Country?
	s 23e	rall	10517 Englishman Dr				852		United	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show early righty or other treumatic event, the Marifeal Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Spean, Mexican, Puerto ban, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. White
21215-0036	72 hou	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Dec	edent's Usual Occu	upation e during most of work	kina	16b. Kind of Bus	
2	nithin 7	mple	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retir	ed)	nii g	_	Library of
2	Hygier Hygier ther ti		17. Father's Name (First, Middle, Last)	5+	Lit	rarian	18 Mother's Nam	ne (First Middle	L1 Maiden Sumame	an
au	id be in the interpretation of the interpretation in the interpret	To Be	Agha Khan Rashidi	i			Robabeh	Attar	, waddin Samamo,	,
Maryland	and M s mar	-	19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mai	ing Address (Stree	at and Number or Ru		er, City or Town, S	tate, Zip Code)
Σ,	and 2 ealth a n 27 i		F. Shohreh Homayour	npour/Daug	-	All of the last of	nman Drive	e, Rockv	ville, Ma	ryland 20852
altimore,	ges 1 it of H if iter or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	20b. Place of Disp cemetery cre Parkla	osition (Name of ematory or other pl LWN	rebr	uary 8,	20c. Location - C	ity or Town, State
<u>=</u>	it. Partmer intentional		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Period License	1	Memorial	Park	20	05	Darmahasasa	e, Maryland Funeral Home/
Ba	Deprit timpo		1 Athan 1 to		0689	ethesda-	Chevy Cha esda, Mar	se, Inc	10111111111111111111111111111111111111	sconsin Avenue
			23a. Part I thte the disease, or complication that the complication is the complication of the complication of the complication of the complication of the complication of the complication of the complication of the complication of the complication of the complication of the complication of the complication of the complete of the com	cations that caused	the death. Do not en	iter the mode of dy	ring, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
A	Physician		Immediate Cause (Final disease or condition		ion Pneumo					Onset and Death
В	/Medical Examiner		resulting in death)		a consequence of):					
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Multiple Due to (or as	a consequence of):					
	cuted nd ransit	Examiner	that initiated events							
ő,	ficate be executed physicien and is the burial-transit	I Ex	resulting in death) Last	Due to (or as	a consequence of):					
8760,	cate b physic the b	dlcal	d				· · · · · · · · · · · · · · · · · · ·			
9 XC	that the death certifined by the attending properties as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, out <i>co</i> me					23d. Date	of delivery
.O. Box	death e atte	icia	in the past 12 months? 1 □ Yes 2 ☒ No	4 Pregnant at		□Ectopic pregnand □ Other (specify)	су		Monti	
<u>Ф</u>	at the	Phys	9 Unknown	9∐ Unknown						
Records,	The law requires that the death certifi tte has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant conditions con	tributing to death b	ut not resulting in the	underlying cause g	iven in Part I.			ute to the cause of death? ☐ Probably 4 ☐ Unknown
al Rec	10 -	Completed						24a. Was autop perfo 1 \square Yes	rmed? pri	ere autopsy findings available or to completion of cause of ath? Yes 2 No
Vital	Physiclen: r this certifica ral director, I	o Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	ospital:	ent 2 🗆 ER/Outpatie	nt 3 DOA	26. Place of Dear			(0)
Division of	ding Physiclen: After this certific funeral director,	\vdash	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry 28b. Time	of 28c, Inju			dence 6 Other now injury occurred	
Sio	tend leath tor: the	catl	2 Accident investigation 3 Suicide 6 Could not be	00 01 11]Yes 2□No		2	
Σ	tel or Attenders after deathel Director:	Certification:	4 Homicide determined	building, et	ury - At home, farm, s c. (Specify)	reet, factory, office		City or Tox		or Rural Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier 1X Certifying Phys (Check only one) 1 Medical Examin	sician: To the best ner: On the basis of and manner sta	of my knowledge, dea f examination and/or in ated.	th occurred at the to nvestigation, in my	ime, date and place, opinion, death occur	and due to the cred at the time,	cause(s) and mann date and place, an	ner as stated. d due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	h	in		se number		29d. Date signed (
,			20 Namada da	malatad assert	and the		660		February	7, 2005
	5		30. Name and addless of person who con Alpana Goswami, M.I				100. Rock	ville N	Marviand	20852_31/-2
	Sta		31. Date filed (Month, Day, Year)	32 Registra	ar's Signature	anti I	LOUS MOCK	VIIIE I	rar y ranu	70077-7147
	Registr	ar	FEB 0 8 2005	A STATE OF S	John May					

			For State Registrar	State of Ma		artment of Health rtificate of Deat		Hygiene Reg. No.	105	3730
	Physici /Medic		Decedent's Name (First, Middle, Last,	LILLIAN	T. R0:	SECRANS	2. Date of Month	Day	- 2005	3. Time of Death 9:30 A. M
4	Examir		4a. Facility Name (If not institution, give CARROLL LUTHERN	VILLAGE		4b. City, Town, or Location		4c. C	ounty of Death	
	Funeral Director		:0 0000		e (In yrs. last birthday) 102 Yrs.	If Under 1 Year If Und Months Days Hours	er 24 Hrs. 8. Date of (Month) 04 – 3	of Birth 1, Day, Year) 30-1902	9. Birthp Cour K A	lace (State or Foreigr http:) NSAS
	Maryland a-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County MD. CARROLL		10c. City, Town or Lo	westminste	R		1	0d. Inside City Limits 1 ☐ Yes 2√XNo
	h with the	ai Dire	10e. Street and Number 200 SAINT LUKE	S CIRCU	_E	10f. Zip Code 21158			on of What Cour	,
920	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I health and Mental Hygiene. I health a 13e or 28e 1 ehow tiem 27 is marked other than "naturel", or item 23e or 28e 1 ehow other treumatic event. The Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married XX Widowed 4 ☐ Divorced	12. Was Decedent It Armed Forces? 1 Yes XXI If Yes, Give Year or Dates:	√o l	Was Decedent of Hispanic (f Yes, specify Cuban, Mexic 1 Yes XX No Speci			. Race - Americ Black, White, pecify: WH	an Indian, etc. I TE
21215-0036	d within 72 ho giene. ar than "natur . The Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12 YEARS	cation completed) College (1-4or S	(Give	dent's Usual Occupation kind of work done during m DO NOT use retired) HOUSEWIFE	ost of working	16b. Kind	of Business/Ind HOME	dustry
Maryland	2 should be filed within and Mental Hygiene. is marked other than eumatic event. In M.	To Be C	17. Father's Name (First, Middle, Last) JOHN	WESLEY	TUCKER		ther's Name (First, Mi ALMA WAG	ddle, Maiden St NER	urname)	
	ind 2 sho alth and h 27 is ma or treuma		19a. Informant's Name/Relationship (Ty, GARY W. ROSECRANS	•		ng Address (Street and Num PARK AVENUE,		-		Code)
Baltimore,	permit. Pages 1 and 2 Department of Health a important: If item 27 is any injury or other tree		20a. Method of Disposition 1 Burial 2 Cremation XXI 4 Donation 5 Other (Specify)	emoval from State	20b. Place of Dispo cemetery, cree PARIRIE	sition (Name of natory or other place) LAWN	Date 02-09-200		ition - City or To	
Balti	permit. Departn imports any inju		21. Signature of Funeral Service License	е		Name and Address of Fac ICK TOWSON FU	•		1050 YO TOWSON,	RK ROAD MD.21204
68760,	Cate be executed / Medical Examiner the burial-transit ithe burial-transit	edicai Examiner	23a. Part1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of):	er the mode of dying, such a	as cardiac or respirato	ry arrest,		Approximate Internal Between Onset and Death Conset and Death Conset and Death Conset and Death
P.O. Box 6		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 9 0 9 Unknown	Sc. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		230	d. Date of deliver	ry Day Year
	quires that the de n signed by the a uld be detached f	þ	Part II. Dther significant conditions con	tributing to death bu	ut not resulting in the ur	nderlying cause given in Par		Did tobacco use		e cause of death?
Il Records,	: The law require cate has been si page 2 should b	Completed					а	utopsy erformed?	24b. Were autop prior to con death? 1 \(\sum \text{Yes}\)	psy findings available apletion of cause of
Division of Vital	Attending Physicien: The law requires that the death certif r death. r death. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Certification; To Be	27. Manner of Death Manner of Death Solition Solition Solition Solition Solition Solition Solition Solition Solition Solition Solition Solition Solition Solition Soliti	ospital: 1 ☐ Inpatier 28a. Date of Injur (Month, Day	y Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2]No	Residence 6 [ccurred	
Div	i Sign		4 Homicide determined 29a. Certifier Certifying Phys		ry - At home, farm, stre. (Specify)	set, factory, office	City or	on (Street and N Town, State)		
	To the Hospital or within 24 hours after To the Funerel Direct completely filled in Inc.	Medical	(Check only one) 2 Medical Examination (Check only one)	er: On the basis of and manner star	examination and/or.in	estigation, in my opinion, de	eath occurred at the tir	me, date and pla	ace, and due to	the cause(s)
			200. Signature and title of centrer	12		D3794	19	Feb.	igned (Month, D	2005
	∖ ^Ɗ Sta		30. Name and address of person who con 31. Date filed (Month, Day, Year)	n let cause of de	r's Signature	Print) Qhoresthen	i Sutit	201, W	esem	den (M)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Vear **Physician** SANTINA FEBRUARY 2005 14:00 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner 224 Oakwood Road Dundalk Baltimore Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1□ M 21 F 92 Yrs Director 212-09-3548 January 8, 1913 MD. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Show Department of Health and Marial Hygiena. Instruction after death with the Meryle Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment must be notified at once. 1 Yes 2 □ No MD. N/A Funeral Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5422 Force Road 21206 USA Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife 12 years Own Home 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Alfio Spinnicchio Michelina Spinnicchio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 309 Leeanne Road, Essex, Maryland 21221 John Joseph Rey son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) February Dulaney Valley Memorial 7, 2005 Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Perf1. Enter the disease of complications that caused the death. Donot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical a SEPSIS 2 DAYS Examiner Due to (or as a consequence of): Examiner WOUND INFECTION MONTHS SACRAL use es the bunal-transit or Attending Physician: The law requires that the death certificeta be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Division of Vital Records, P.O. Box 68760, 5 MONTHS attending physician DEBILITY by Physician/Medical Due to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown DIABETES, URINARY INCONTINENCE 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No this cartificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Care were 1 ☐ Yes 2 🔼 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: Aftar this filled in by the funeral 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by tha fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifie Medical and manner stated th. 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier Dook 9039 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 HOPKINS BAYVIEW CIRCLE BALTIMORE, MD Hayash MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 08 2005

KG 			1 - For Unpe State Unpe Registrar			a,27,	28a-f	per	me G	842 rtificat	e of l	55"ta Death	and IV	ientai Hy	/gien Reg. N	201	95	0373	32
р	hysicia	n	Decedent's Name											2. Date of D Month		ay	Year	3. Time of Dea	
	/Medic	al.	ABBIGA											Febru	-		005	9:47	A ^M
E	xamin	er	Johns Hop		-			1			lown, or	Location of	of Death		4	c. County N/A	of Death		
O Eu	nerat		5. Social Security No		6. Sex	CW 110	7. Age (In		birthday)	If Unde	1 Year	If Under		8. Date of B	irth		9. Birthpi	lace (State or Fo	 oreian
	ector		216-71-92 Usual Residence of		1 🗆 !	M 2 DXF			Yrs.	Months 1	Days	Hours	Min.	8. Date of Bi (Month, D	ay, Year 2005		MARY	LAND	
land	ad at		10a. State	10b. County			100	c. City, To	wn or Lo	cation							10	Od. Inside City Li	imits
aryland 21215-0036 should be tiled within 72 hours after death with the Maryland nd Mental Hyglene.	iteni s.f. is markeu ciriet mari Hakurar, si renis s.ea ci soari emo other traumatic event, tra Marilgal Exarta nel mat se cartified at	tor	MD	FREI	DERI	CK		FF	REDE	RICK								1 Tes 2	XNο
th the	or coulffs	Funeral Director	10e. Street and Num	nber						10f. Zip	Code				10g. C	itizen of V	/hat Coun	try?	
ath wi	USE	ral	6960 EXE	ETER CO		APT					2170					USA			
ar de	la la la la la la la la la la la la la l	nue	11. Marital Status			2. Was Dec Armed Fo	edent Ever	in U.S.	13.	Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Ori n, Mexican	igin? (Spe n, Puerto	ecify Yes or N Rican, etc.)	0-		- Americ k, White, e		
)36 irs aft	Marrie D.	by F	X□ Never Marrie 3 □ Widowed			1 Tyes If Yes, Gi Year or D	ve			1 🗆 Yes	2 🛛 No	Specify:				Specify	WH	ITE	
2 bot	cical Exem	ted	/6	15. Deceden	t's Educa	ation		16	ia. Dece	dent's Usu	al Occupa	ation			16b. I	Kind of Bu	siness/Inc	lustry	
215 thin 7	Med	Completed	Elementary/Secon	ify only highe: ndary (0-12)	st grade	College (1-4or 5+)		life.	DO NOT u	rx done d se retired	during mos	t of worki	ng					
21 w jegien	T, Et	Con	n/a						n/a	a						/a			
laryland 2121 2 should be tiled within	90.00	Be	17. Father's Name (First, Middle,	Last)									(First, Middle		n Sumam	9)		
ryk bould d Mei	matic	ြ	19a. Informant's Na	me/Relations	hin (Tyne	e Print)		10	ah Mailie	na Address	/Street			SHYRO		or Tourn	State Zin	Code	
	trau		DANIELLE					1		EXET								21703	
Baltimore, Maryland 21215-0036 Demrit. Pages I and 2 should be tiled within 72 hours at	eny injury or other tra		20a. Method of Disp	osition				0b. Place	of Dispo	sition (Nar	ne of			Date		ocation -	-		
mo Page Page	ry or		1 ☐ Burial 2 ☐ `4 ☐ Donation			moval from	State		-	-			2/8/	2005	Cat	onsv:	ille.	MD	
Balti permit. Departm	eny inju		21. Signature of Fur	neral Service	Licensee													ME, P.A.	
n &å!	58		12						8	521 L	OCH I	RAVEN	BLV	D. TOW	SON,	MD 2	21286		
,	wj.		23a. Part1. Enter th shock, or hear	e disease, or t failure. List	complications only one	ations that of cause on e	caused the each line.	death. D	o not ent	er the mod	le of dying	g, such as	cardiac c	or respiratory a	arrest,			Approximate Interval Between	
Phys			Immediate Cause (I disease or condition resulting in death)	Final 1	a.	Sudde	n Une	expla	ined	Deat	hin	Infa	ancy	(SUDI)				Onset and Death	n
/Me Exan	dical- niner		resulting in death)			Due to	(or as a co	nsequenc	e of):										
JE N		i i	Sequentially list con	nditions,	b.	Due to	(or as a co	nseauenc	e of):										
petr	ansit	Examiner	Sequentially list con if any, leading to im cause. Enter under Cause (Disease or i that initiated events	riying injury	(
o,	burial-transit	Exa	resulting in death) L	ast	C.	Due to	(or as a cor	nsequenc	e of):			·	· · · · · ·						
8760, ate be ex	the burial	cal			d.														
r 68	as th	Med	IF FEMALE:																
Box eath cert	for use as	lan/I	23b. Was decedent in the past 12 i		230		oirth 2 🗌	Fetal dea		Ectopic p						23d. Date Mon	of delive	y Day Year	
P.O. I	tached f	Physician/Med	1 ☐ Yes 2 ☐ 9 ☐ Unknown		i i	4∐ Pregr 9□ Unkn	nant at time own	of death	5	Other (sp	ecify)					14101		ou) rour	
that th	be detac	/ Ph	Part II. Other signifi	cant condition	ons contr	ributing to d	eath but no	ot resulting	in the u	nderlying o	ause give	n in Part I.		23e. Did	tobacco	use contr	bute to the	a cause of death	?
Division of Vital Records, P.O. Box 68760, I or Attending Physician: The law requires that the death certificate be executed after death.	ed blu	d by												1 🗆	Yes 2	₽No	3 🗌 Proba	ıbly 4 ⊟Unkno	own
CO	2 should l	ojete												24a. Was		24b. V	/ere autop	sy findings availa	able
Re Is	page 2	Completed													psy ormed? 2 \(\sumbole \) No	p	rior to com eatb?	pletion of cause 2□ No	of
ital	5 0	BeC	25. Was case referr	ed to medical								26. Place	of Death	(Check only		,			
of V	2 5	10 8	examiner? 1 ∑X es 2□1	No	Но	spital: 1 🗆	Inpatient	2 (XER/0	Outpatier	it 3 DC	Othe	er: 4 □ Nu	rsing Hor	ne 5□Res	idence	6 Othe	r (Specify,)	
n C	tuneral	on;	27. Manner of Death 1 ☐ Natural	5 Pendin	g	28a. Date (Mon	of Injury th, Day Yea	ar) Fo	una:		8c. Injury Work			28d. Describe	how inju	iry occurre	d unk		
isio Itendi	the t	cati	2 Accident 3 Suicide	investig 6 X] Could i		2-4-0	-	_		A M		res 2 1		206 1					
Oiv A	in by	Certification;	4 Homicide	determ	ined	Resid	of Injury - ing, etc. (S)	pecify)	rarm, str	eet, factor	, office							eii Number Ave	
Hospitel Hospitel	tilled		29a, Certifier	1 Certifyin	a Physic			v knowled	ge. deatl	occurred	at the tim	e date and		Junda.Lk and due to the				County,	MD
Division To the Hospitel or Attent within 24 hours after death	completely tilled in	Medical	(Check only one)	2 ∑ Medical	Examine	er: On the b	asis of exa ner stated.	mination a	and/or in	vestigation	in my op	pinion, deat	th occurr	ed at the time,	date an	d place, a	nd due to	the cause(s)	
To th	dwoo	M	29b. Signature and	litle of certifie	1/	/	N	1		290	. License	number			29d. Da	ate signed	(Month, E	ay, Year)	
				101	X	1	1	1			0.C.	M.E.		F	ebru'	ıary	5, 20	005	
_			30. Name and addre	ess of person	who com	pieted cal	se of death		1	11 Pa	enn S	Street	t, Ba	altimor	e, l	Maryl	and 2	21201	
	Sta	te	31. Date filed (Mont	EB 0°8	200	3 4	legistrar's S	Signatue	La	whi									
, A	egistra	ar		0 0	UU.	- Jud			1										

			for State	State of Ma		artment of Health and <i>rtificate of Death</i>	Mental Hy	giene 005	03733
		_	Registrar 1. Decedent's Name (First, Middle,	Lasti		Tillicale of Dealif	2. Date of De	Reg. No.	
	Physici	an		,			Month	Day Year	3. Time of Death
	/Medic		John R. 4a. Facility Name (If not institution,			4b. City, Town, or Location of De	Februar		2;20PM
	Examin	er	Charlestown Care			Catonsville	ath	4c. County of Death	
					e (In yrs. last birthday)	If Under 1 Year If Under 24 H	rs. R Date of Bird	Baltimo	
	Funeral Director		579-54-8680 Usual Residence of Decedent	1X M 2□F	93 Yrs.	Months Days Hours M		y, Year) 0, 1911 Nev	pplace (State or Foreign intrx) VYOPK
	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation			10d. Inside City Limits
	Man,	ğ	Maryland Balti	imore	Catonsv	7 i 11 e			1 ☐ Yes 2 ☐XNo
	1 28a	Director	10e. Street and Number			10f. Zip Code		10g. Citizen of What Cou	untry?
	3a o		717 Maiden Choic	se Iane Ant	/1/	21228		USA	
	ms 2	Funeral	11. Marital Status	12. Was Decedent B		Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No		ican Indian,
ဖ	after or Ite	Ē	1 Never Married 2 Marrie	Armed Forces? d 1X Yes 2 □ N	6193/ I		erto Rican, etc.)		
වී	ours a	چ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1955	1 ☐ Yes 2 ☑ No Specify:		Specify: Whi	te
20	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show he Majical Everities mast be notified at	Completed by	15. Decedent's (Specify only highest	Education	16a. Dece	dent's Usual Occupation	vadeina	16b. Kind of Business/I	ndustry
2	thin e	햩	Elementary/Secondary (0-12)	College (1-4or 5	+)	kind of work done during most of v DO NOT use retired)	vorking		,
2	ed w ygier er tt	ပ်		5+	Inte	rpreter		Marine Corp	os/ Teacher
2	d ott	Be	17. Father's Name (First, Middle, L.	ast)			lame (First, Middle, —		
<u>×</u>	Ment Ment arke atic	မှ	Robert Shaw			Charl	otte Trac	² y	
Maryland 21215-0036	2 sh and is m		19a. Informant's Name/Relationshi	р (Туре, Print)		ng Address (Street and Number or			
2	and ealth m 27 ner tr		Sara J. Shaw, Wi	lfe	717 M	Maiden Choice La			
ore	of H of H if Item		20a. Method of Disposition 1 ☐ Burial 2√☐ Cremation	Removal from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place)	Date	20c. Location - City or 1	own, State
Ē	Pag ment ant: I		* 4 □ Donation * 5 □ Other (Spe	ecify)	Metro Cr	ematory Inc. 02,	/02/05	Baltimore,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. San proportant: If them 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Marileal Erectinet mast be notified at once.		21. Signature of Funeral Service	censee	22	2. Name and Address of Facility	· Of Moses	land Tna	
_	20 E # 9		Thomas Gregor		\	Cremation Society 199 Frederick Ro	ad Baltim	ore. Maryla	nd 21228
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that caused nly one cause on each lin	the death. Do not ent	ter the mode of dying, such as card	iac or respiratory ar	rest,	Approximate Interval Between
ı	Physician		Immediate Cause (Final disease or condition	- PONCE	The second second	ancer			Onset and Death
	/Medical	11.1	resulting in death)		a consequence of):				WEEKS
	Examiner		Sequentially list conditions	b					
	ס ≓	ē	if any, leading to immediate	Due to (or as a	·				
	d d		cause. Enter Underlying	0	a consequence or):				
	5 5 5	amlı	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с					
o,	e exec	I Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	a consequence of):				
9760,	ate be executed hysician and the burial-transit	cal	that initiated events	c					
(68760,	ortificate be executed ing physician and e as the burial-transit	cal	resulting in death) Last	d	a consequence of):				
3ox 68760,	ath certificate be exected and physician and to use as the burial-tra	cal	resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	d	a consequence of): of pregnancy 2 Fetal death 3	□Ectopic pregnancy		23d. Date of deliv	
D. Box 68760,	e death certificate be exec the attending physician and hed for use as the burial-tr	cal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d	a consequence of): of pregnancy 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delik Month	very Day Year
P.O. Box 68760,	nat the death certificate be exec d by the attending physician and letached for use as the burial-tr	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d. 23c. If yes, outcome 1	a consequence of): of pregnancy 2	Other (specify)	22a Didu	Month	Day Year
P.O. Box 68	res that the death certificate be exec signed by the attending physician and the detached for use as the burial-tr	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d. 23c. If yes, outcome 1	a consequence of): of pregnancy 2	Other (specify)		Month bacco use contribute to	Day Year the cause of death?
P.O. Box 68	requires that the death certificate be exec een signed by the attending physician an rould be detached for use as the burial-Itr	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d. 23c. If yes, outcome 1	a consequence of): of pregnancy 2	Other (specify)		Month	Day Year the cause of death?
P.O. Box 68	v requires that the death cert been signed by the attending should be detached for use a	by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d. 23c. If yes, outcome 1	a consequence of): of pregnancy 2	Other (specify)	1 1 3	Month obacco use contribute to fes 2 No 3 Pro an 24b. Were aut prior to co	Day Year the cause of death?
P.O. Box 68	v requires that the death cert been signed by the attending should be detached for use a	by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d. 23c. If yes, outcome 1	a consequence of): of pregnancy 2	Other (specify)	1 1 3	Month bbacco use contribute to fes 2 \(\text{No} \) 3 \(\text{Prc} \) an 24b. Were aut	the cause of death? bably 4 Unknown opsy findings available
P.O. Box 68	v requires that the death cert been signed by the attending should be detached for use a	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d. 23c. If yes, outcome 1	a consequence of): of pregnancy 2	Other (specify) nderlying cause given in Part I.	24a. Was	Month obacco use contribute to fes 2 No 3 Pro an 24b. Were aut ssy med 2 death? 27 No 1 Yes	the cause of death? bably 4 Unknown opsy findings available ompletion of cause of
P.O. Box 68	v requires that the death cert been signed by the attending should be detached for use a	To Be Completed by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. 23c. If yes, outcome 1	a consequence of): of pregnancy 2 Fetal death 3 time of death 5 time of death 5 time of death 3 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 6 time of death	Other (specify) nderlying cause given in Part I. 26. Place of Date 3 DOA	24a. Was autop perfo	Month obacco use contribute to fes 2 No 3 Pro an 24b. Were aut ssy med 2 death? 27 No 1 Yes	the cause of death? bably 4 Unknown opsy findings available ompletion of cause of
P.O. Box 68	v requires that the death cert been signed by the attending should be detached for use a	To Be Completed by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	d. 23c. If yes, outcome 1	a consequence of): of pregnancy 2	26. Place of Date of D	24a. Was autop perfo 1 Yes autop perfo 1 Yes autop perfo 1 Yes autop perfo 5 Residual	Month bbacco use contribute to fes 2 No 3 Pro an 24b. Were aut prior to ci death? 2P No 1 Yes	the cause of death? bably 4 Unknown opsy findings available ompletion of cause of
P.O. Box 68	v requires that the death cert been signed by the attending should be detached for use a	To Be Completed by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1	a consequence of): of pregnancy 2	26. Place of Dark 3 DOA Other: 4 Nursing Work? M 1 Yes 2 No	24a. Was autop perfo 1 Yes autop perfo 1 Yes autop perfo 1 Yes autop perfo 5 Residual	Month obacco use contribute to fes 2 No 3 Pro an 24b. Were aut prior to cideath? 22 No 1 Yes dence 6 Other (Special	the cause of death? bably 4 Unknown opsy findings available ompletion of cause of
vision of Vital Records, P.O. Box 68	v requires that the death cert been signed by the attending should be detached for use a	To Be Completed by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1	of pregnancy 2 Fetal death 3 time of death 5 time of death 6 t	26. Place of Dark 3 DOA Other: 4 Nursing Work? M 1 Yes 2 No	24a. Was autop performed to the control of the cont	Month obacco use contribute to Yes 2 No 3 Pro an 24b. Were aut prior to cideath? 24 No 1 Yes dence 6 Other (Special Common C	the cause of death? bably 4 Unknown opsy findings available ompletion of cause of 2 No
vision of Vital Records, P.O. Box 68	v requires that the death cert been signed by the attending should be detached for use a	Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1	a consequence of): of pregnancy 2	26. Place of Dart 3 DOA Other: 4 Nursing Work? M 1 Yes 2 No reet, factory, office	24a. Was autop performed to the control of the cont	Month obacco use contribute to fes 2 No 3 Pro an 24b. Were aut prior to codeath? 22 No 1 Yes ne) dence 6 Other (Special Common Street and Number or Runn, State)	the cause of death? bably 4 Unknown opsy findings available ompletion of cause of 2 No ify)
vision of Vital Records, P.O. Box 68	v requires that the death cert been signed by the attending should be detached for use a	Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. 23c. If yes, outcome 1	a consequence of): of pregnancy 2	26. Place of Dark 3 DOA Other: 4 Nursing Work? M 1 Yes 2 No	24a. Was autop performed to the control of the cont	Month bbacco use contribute to fes 2 No 3 Pro an 24b. Were aut prior to c death? 22 No 1 Yes ne) dence 6 Other (Spectow injury occurred Street and Number or Rui cause(s) and manner as	the cause of death? bably 4 Unknown opsy findings available ompletion of cause of 2 No all Route Number,
vision of Vital Records, P.O. Box 68	r Hospitat or Attending Physician: The law requires that the death cert. 24 hours after death. 24 hours after death. Funnaral Director: Atter this certificate has been signed by the attending alley filled in by the funeral director, page 2 should be detached for use its after this content of the funeral director.	To Be Completed by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1	a consequence of): of pregnancy 2	Other (specify) nderlying cause given in Part I. 26. Place of Date o	24a. Was autop performed at the time, we carried at the time,	Month bacco use contribute to fes 2 No 3 Pro an 24b. Were aut prior to codeath? 1 Yes ane) dence 6 Other (Spectow injury occurred Citreet and Number or Run Cause(s) and manner as date and place, and due	the cause of death? shably 4 Unknown opsy findings available ompletion of cause of 2 No ify) ral Route Number, stated. to the cause(s)
vision of Vital Records, P.O. Box 68	I or Attending Physician: The law requires that the death cert alred death. Jitector After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use it.	Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. 23c. If yes, outcome 1	a consequence of): of pregnancy 2	26. Place of Date of D	24a. Was autop performed at the time, we carried at the time,	Month bbacco use contribute to fes 2 No 3 Pro an 24b. Were aut prior to c death? 22 No 1 Yes ne) dence 6 Other (Spectow injury occurred Street and Number or Rui cause(s) and manner as	the cause of death? shably 4 Unknown opsy findings available ompletion of cause of 2 No ify) ral Route Number, stated. to the cause(s)
vision of Vital Records, P.O. Box 68	r Hospitat or Attending Physician: The law requires that the death cert. 24 hours after death. 24 hours after death. Funnaral Director: Atter this certificate has been signed by the attending alley filled in by the funeral director, page 2 should be detached for use its after this content of the funeral director.	Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. 23c. If yes, outcome 1	of pregnancy 2 Fetal death 3 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of linjury 28b. Time of l	26. Place of Date 3 DOA Other: 4 Nursing f 28c. Injury at Work? M 1 Yes 2 No reet, factory, office h occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation.	24a. Was autop performed at the time, we carried at the time,	Month bacco use contribute to fes 2 No 3 Pro an 24b. Were aut prior to codeath? 1 Yes ane) dence 6 Other (Spectow injury occurred Citreet and Number or Run Cause(s) and manner as date and place, and due	the cause of death? shably 4 Unknown opsy findings available ompletion of cause of 2 No ify) ral Route Number, stated. to the cause(s)
vision of Vital Records, P.O. Box 68	r Hospitat or Attending Physician: The law requires that the death cert. 24 hours after death. 24 hours after death. Funnaral Director: Atter this certificate has been signed by the attending alley filled in by the funeral director, page 2 should be detached for use its after this content of the funeral director.	Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. 23c. If yes, outcome 1	of pregnancy 2 Fetal death 3 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of linjury 28b. Time of linjury 2b. Time of l	26. Place of Date 3 DOA Other: 4 Nursing f 28c. Injury at Work? M 1 Yes 2 No reet, factory, office h occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, and the time, date and playestigation, and the time, date and playestigation, and the time, date and playestigation, and the time, date and playestigation, and the time, date and playestigation, and the time, date and playestigation at the time, date and playestigation at the time, date and playestigation at the time, date and playestigation at the time, date and playestigation at the time, date and playestigation at the time, date and playestigation at the time, date and playestigation at the time, date and playestigation at the t	24a. Was autoperformer of the course of the	Month bacco use contribute to fes 2 No 3 Pro an 24b. Were aut prior to codeath? 1 Yes ane) dence 6 Other (Spectow injury occurred Citreet and Number or Run Cause(s) and manner as date and place, and due	the cause of death? the cause of death? thably 4 Unknown opsy findings available ompletion of cause of 2 No ify) ral Route Number, stated, to the cause(s) Day, Year)
vision of Vital Records, P.O. Box 68	r Hospitat or Attending Physician: The law requires that the death cert. 24 hours after death. 24 hours after death. Funnaral Director: Atter this certificate has been signed by the attending alley filled in by the funeral director, page 2 should be detached for use its after this content of the funeral director.	Medical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1	of pregnancy 2 Fetal death 3 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of death 5 time of linjury 28b. Time of linjury 2b. Time of l	26. Place of Date 3 DOA Other: 4 Nursing f 28c. Injury at Work? M 1 Yes 2 No reet, factory, office h occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation, in my opinion, death occurred at the time, date and playestigation.	24a. Was autoperformer of the course of the	Month bacco use contribute to fes 2 No 3 Pro an 24b. Were aut prior to codeath? 1 Yes ane) dence 6 Other (Spectow injury occurred Citreet and Number or Run Cause(s) and manner as date and place, and due	the cause of death? the cause of death? thably 4 Unknown opsy findings available ompletion of cause of 2 No ify) ral Route Number, stated, to the cause(s) Day, Year)

			_ For	State of Maryla				•	•).
			1 - State Registrar		Ce	rtificate of	Death	Re	g. No.200	5 03734
	Physic	ian	Decedent's Name (First, Middle, Last)					Date of Death Month	Day Ye	3. Time of Death
	/Medi	cal		Carole Sic	chette			February	4, 2005	
	Exami	ner	4a. Facility Name (If not institution, give 100 Seminole Aver				or Location of Death		4c. County of D	
	Funeral		5. Social Security Number 6. Sec		s. last birthday)	Catonsv If Under 1 Year		8. Date of Birth	Balti	
	Director			M 20 F 6		Months Days		8. Date of Birth (Month, Day, 1)	1940	Birthplace (State or Foreign Country) Ohio
	p ,		Usual Residence of Decedent	100	O'1. T.			010 10,	2710	
	ehow	7	10a. State 10b. County Marvland Baltimore		City, Town or Lo	cation tonsville	2			10d. Inside City Limits 1 ☐ Yes 2X No
	28a-f	ect	Maryland Baltimore		- Va			10	- 02:	
	with Ba or	ā	100 Seminole Ave	nuo		10f. Zip Code 2122	28	10	g. Citizen of What	
	deeth me 2:	era		12. Was Decedent Ever in	U.S. 13.		Hispanic Origin? (Specian, Mexican, Puerto P	eify Yes or No-	USA 14. Race - A	merican Indian,
9	or Ite	Ē	1 ☐ Never Married 2 📉 Married	Armed Forces? 1 ☐ Yes 2 X No				lican, etc.)		/hite, etc.
33	ours iral',	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specity:		Specify:	White
21215-0036	within 72 hours after deeth with the Maryland sne. than "natural", or Iteme 23s or 28s-f ehow the Medical Examiner must be notified at	Completed by Funeral Director	15. Decedent's Edu (Specify only highest grade		16a. Dece	dent's Usual Occur kind of work done	pation during most of workin d)	g 11	6b. Kind of Busine	
12	withir ene than	μ̈́	Elementary/Secondary (0-12)	College (1-4or 5+)		ial Worke			Departm	
	Hygie other ent. II	Be Co	17. Father's Name (First, Middle, Last)		1000	Lai Wolke	18. Mother's Name	(First, Middle, Ma		Services
lan	should be and Mental is marked o	To B	Marvin Crawford				Florer	nce Snyd	er	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, ILE M.	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Street	and Number or Rural			e, Zip Code)
	and 2 salth a n 27 le		Dominic M. Sichett		100 \$	Seminole	Avenue Cat	onsvill	e. MD 21	228
ore	Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla hent of Health and Mental Hygiene. int: If Item 27 Ie marked other than "natural", or Iteme 23s or 28s-f ehov yor other treumatic event. It a Medical Examiner must be notified at		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	emoval from State	 Place of Dispo cemetery, crer 	sition (Name of matory or other pla	ce) Da	ite 20	oc. Location - City	or Town, State
Baltimore,	artment ortent: njury		`4 □Donation 15 □ Other (Specify)	Me		ematory,				ore, MD
Bal	permit. Pages 1 and 2 Department of Health a Importent: If item 27 It any njury or other tre once:		21. Signature of Funeral Service License	gordon			Society of			
			Edward A. Green	rchik	120	99 Freder	rick Road F	Raltimor	e, MD 21	228 Approximate
			23a. Part1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	atti. Bo'not ent	er the mode of dyn				Interval Between Onset and Death
0	Physician /Medical		disease or condition resulting in death)	Due to (or as a	equence of):	e hea	it fai	luce		15 years
	Examiner		f.	Dilate	d a	endin.	mun Dat	ture		15 years
	P #	ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	equence of):		50	0		9.00
	ecuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
760,	ite be executed ysicien and ne burial-transit	cal Ex	resolving in death) cast	Due to (or as a conse	equence of):					
687	~ > 9					. = = 1 = = =				
×	eath certifica attending ph for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of preg	nancy				23d. Date of	dolivon
Box	d for u	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)	у		Month	Day Year
P.0	by the datached	hys	9 Unknown	9□ Unknown						
	gned gned	by P	Part II. Other significant conditions cor				ven in Part I.	23e. Did toba	cco use contribute	to the cause of death?
ord	w require been sis		Diabetes,	typer iper	denic	રે		1 🗆 Yes	2 No 3	Probably 4 Monknown
Vital Records,	e law has by	Completed						24a. Was an autopsy	prior	autopsy findings available to completion of cause of
al R								performe		? ′es 2□ No
Vit.	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		O#	26. Place of Death			
of	Phys rrthis sral di	. To	1 ☐ Yes 2 ☑ No 27. Manper of Death	28a. Date of Injury	ER/Outpatien 28b. Time of		ner: 4 ☐ Nursing Hom	e 5 👿 Residen: 3d. Describe how	ce 6 Other (S	pecify)
lon	nding f th. r: After e funer	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injur Wor M 1 🗆	rk? Yes 2 □ No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division	Attendi er death. ector: A by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office	28	8f. Location (Stre City or Town,	et and Number or	Rural Route Number,
Ö	tel or rs efte el Dir ed in	Cert	4	1					,	
	To the Hospitel or Attending within 24 hours efter death. To the Funerel Director: After completely filled in by the funer	edicai	Check only 2 Medical Examili	sician: To the best of my kner: On the basis of exami	nowledge, death	occurred at the tir	me, date and place, ar	d due to the cau	se(s) and manner	as stated.
	the I	Med	Une;	and manner stated.		29c. Licens				
	5 1 × 10		29b. Signature and title of certifier	(Cinn)		D 3/7	-		I. Date signed (Mo	
7	1		30. Name and address of person who co	moleted cause of death "	om 22a\ /T	0.0			'ebruary	
	γ\		Ragrat Y- (Sirals M	·)) •	724 N	laiden a	Ligice L	A. 2	1228
	Sta	ate	31. Date filed (Menth, Day, Year)	32. Pogiatrar's Sig	nature		person La	4/00	,-	
	Regist	rar	FEB 0 8 201	75 Alaena	He A	200				

DHMH 17 Rev 1/2001

4

			For State	Please 1	ype or Pri State of M		nd / Depa	artme	nt of H	lealth and		-		_	le.	37	35
			1 - State Registrar	- (Final Adiation I and	<u> </u>		Ce	πιτιςε	ite or	Death			Reg. No				-15
	Physici /Media		Charlie	e (First, Middle, Last) Woodrow Sn	nith			1			F	Date of Dea Month ebruar	y 5	, 200		3. Time	of Death
	Examir	ner		f not institution, give Geriatric				1	•	r Location of Dea e River	th		4c.	County o		æ	
I	Funeral Director		5. Social Security N 239 26 76	27 15	7. Aq M 2□F 9		last birthday) Yrs.	If Und Month	er 1 Year s Days	If Under 24 Hrs Hours Min		Date of Birt (Month, Day					e or Foreigr colina
	and w		Usual Residence of 10a. State	Decedent 10b. County		10c. Ci	ty, Town or Lo	ocation								10d. Inside	City Limits
	e Maryl	ctor	Maryland	Baltimore	9		Middle		er								es 2½ No
	3e or 2t	i Director	10e. Street and Nut 560 Compa					10f. 2	Zip Code 2122	0			_	izen <i>o</i> f WI JSA	hat Cou	ntry?	
3	d within 72 hours after death with the Maryland speed. Then't har natural, or items 23e or 28e-(show ite Madical Exacter must be relifted at	by Funer	11. Marital Status	ied 2 Married	12. Was Decedent Armed Forces 1 Yes 2 If If Yes, Give Year or Dates:	?		If Yes, s	cedent of F becify Cubi 2 ☑ No	lispanic Origin? (an, Mexican, Pue Specify:	Specif rto Ric	y Yes or No- an, etc.)			, White,		
	n 72 ho natur	Completed	(Spec	15. Decedent's Edu			16a. Dece	kind of	sual Occup work done	during most of wo	orking		16b. K	ind of Bus	iness/in	dustry	
1	filed within Hygiene. Ither than ont, It e Mes	d Lic	Elementary/Seco	ondary (0-12)	College (1-4or	5+)				chnician	ı	}	Aer	ospa	ce		
	al Hyg	3e		(First, Middle, Last)	:h					18. Mother's Na Georgia	me (F		Maiden				
aly	2 should be and Menta is marked aumatic ev	۲	19a. Informant's N	ame/Relationship (Ty	pe, Print)		19b. Maili	ng Addre	ss (Street	and Number or F	iural A	oute Numbe	r, City o	r Town, S	tate, Zip	Code)	
_	att tr		Bettye Gr 20a. Method of Dis	camlich (D	aughter)	30b	4215 Place of Dispo			Road N	Date	inghan	, M	ryla	nd i	21236	
Daiminore,	permit. Pages 1 a Department of He Important: If Item eny injury or othe once.		1 ☑ Burial 2	□Cremation 3 □F	lemoval from State		cemetery, crei	matory`o	r other plai		Date			iltim	•	own, State Md.	
	mit. P partme portar y injur		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A.														
ם ב	88 18 8		Much	rel Ca	Talkar	5.	11.	107	71 <i>a</i> E	atom 7	T707	Te	COV	Md.	_212	221	
	Physician /Medical Examiner		shock, or hea Immediate Cause disease or condition resulting in death)		Due to (or as	220	lenti	c (aro	Hounso	ارا	ar D	ije	case	2	Approxim Interval E Onset an	Between
,	be executed sician and burial-transit	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated events resulting in death)	nmediate erlying injury s	Due to (or as												
	cate be chysicia the buri	a			d												
. בס	thet the death certiticate led by the attending physic detached for use as the total led the total led total led to the total led to the total led to the total led tot	Physician/Medic	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 (9 Unknown	months?	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fet	eldeath 3[⊒Ectopic ⊒ Other (pregnancy specify) _	1				23d. Date Mont		ery Day	Year
ָר טי ר	ures thet signed b Id be deta	þ	Part II. Other signif	ficant conditions cor	ntributing to death I	out not re	sulting in the u	nderlying	j cause giv	ren in Part I.		23e. Did to	bacco u		oute to th		of death? @Unknown
	The law requires thet the ate has been signed by th page 2 should be detache	Completed												pri de	ior to co ath?	ppsy finding impletion o	gs available of cause of
VICAL	ysician: Th is certificate director, pag	Be	25. Was case refer examiner?		de enitely			Victoria e		26. Place of De	ath (C	heck only o	ne)				
5 6	Phys this ral dir	6	1 ☐ Yes 2 ☐ 27. Manner of Deat	INO	fospital: 1 ☐ Inpati 28a. Date of Inji		ER/Outpatier 28b. Time o			- <u>Lu</u> (40,0)(19	_	5 Resid				(y)	
	Attanding I ir death. ector: After by the funer	ation	1 XNatural 2 ☐ Accident	5 Pending investigation	(Month, De	y Year)	Injury	м	28c. Injur Wor 1 🗀	k? Yes 2 □ No	200	. Describe ii	OW IIIJUI	у оссыпе	u		
DISION	ai or Attanos after death	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of In building, e	jury - At h tc. <i>(Speci</i>	ome, farm, str fy)	reet, fact	ory, office		28f.	Location (S City or Tow	treet an m, State	d Number	or Rure	al Route N	umber,
	To the Hospital or within 24 hours after To the Funerel Direction Completely filled in b	edical (29a. Certifier (Check only one)	1 y Certifying Phy 2 Medical Exami	sicien: To the best ner: On the basis of and manner si	of examin.	owledge, deat ation and/or in	h occurre vestigati	ed at the til	me, date and place pinion, death occ	e, and	due to the cat the time, c	ause(s) date and	and man	ner as s	tated. the cause	e(s)
	ro the within: To the comple	Med	29b. Signature and	title of certifier	and manner 5	aleu.		2	9c. Licens	e number		:	29d. Da	te signed	(Month,	Day, Year	·)
,)			/ii1 =					DY	3725	_		2	17	10	Sin	2125
	6		30. Name and addr	ress of person who co	empleted cause of		m 23a) (Type,	Print)	Bar	S125	2~	Necl	c 11	cl	Bo	thin	nuc
	Sta		31. Date filed (Mon		32. Regist				5000	(010/0	- /	VECT	_ 40	-0(-11	-
	Regist	rar	FE	B 0 8 2005	Mache	A.	A334	2									

Battimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exam has must be notified at

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	. For	Type or Print i State of Mary	land / De	partment of H	ealth and M	-	_	03736	
	1 - State Registrar 1. Decedent's Name (First, Middle, La	st)		ertificate of E	eath	Reg. I 2. Date of Death		3. Time of Death	
cian lical	M. Jeannette S					TEBRUARY	14 2005	- 647AM	
iner Il r	4a. Facility Name (If not institution, giv	EL HOSPITA	yrs. last birthd	Months Days	Ocation of Death	8. Date of Birth (Month, Day, Yea NOV. 18,	4c. County of Deat ANNE 9. Birt Co	ARUNDEL hplace (State or Foreign untry) MA	
tor	10a. State 10b. County	Arundel	: City, Town or		Millersvi	lle		10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
ai Direc	10e. Street and Number 90 Kinder Way			10f. Zip Code 21	108	10g.	Citizen of What Co	untry? USA	
Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☆ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates;	in U.S. 1	3. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2X No	panic Origin? (Spe , Mexican, Puerto f Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:		
mpieted	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	/G	ecedent's Usual Occupa ive kind of work done di e. DO NOT use retired) Teache	ring most of workin	g	Kind of Business/	Industry Education	
To Be Co	17. Father's Name (First, Middle, Last, John M. O'Hara				18. Mother's Name	(First, Middle, Maid ertrude C			
	19a. Informant's Name/Relationship (Sheila Rabaglia			ailing Address (Street a Kinder Way				(ip Code)	
	20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specification)	Removal from State	cemetery, o	sposition (Name of crematory or other place Crematory		11.	Location - City or		
	21. Signature of Funeral Service Licer	Eln		22. Name and Address Barranco & 495 Gov. R	of Facility Sons, P.	A. Severn	a Park Fi	uneral Home MD 21146	
Examiner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, bedding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line. Premo Due to (or as a continuo de la con	NTA nsequence of): NAL Au nsequence of):	ORTIC AM		respiratory arrest,		Approximate Interval Between Onset and Death /4 OA YS	
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23d. Date of deli Month							
ted by	Part II. Other significant conditions of CHINNEC OBSTRU		resulting in the				o use contribute to 2 □ No 3 Pr	the cause of death? Obably 4 Unknown	
						24a. Was an autopsy performed 1 Yes 2 A	prior to death?	topsy findings available completion of cause of 21 No	
To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 ☐ ER/Outpa 28b. Time	tient 3 DOA Other		ie 5 ☐ Residence		ify)	
Medical Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	(Month, Day Yea	nr) Injur	y Work' M 1 □ Y	es 2 🗆 No	Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
edical (29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Exam	ysician: To the best of my niner: On the basis of exa and manner stated.	knowledge, de mination and/or	eath occurred at the time r investigation, in my opi	, date and place, a nion, death occurre	nd due to the cause d at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)	
W	29b. Signature and title of certifier	A, ne						, Day, Year) 4 2005	
	30. Name and address of person who	M, 10 N. 6	REENE	STREET	BALTER	DORE, MO	21201		
tate trar	31. Date filed (Month, Day, Year) FEB 0 8 2	32. Pisistrar's S	ilgnature	Sperte					
2001				10					

				State of Maryla				-	•				
			1 - For State Registrar	Otate of Maryta		rtificate of			g. No. 005	03737			
	Physici		1. Decedent's Name (First, Middle, Last) Elizabeth K.					2. Date of Death	h Day Year	3. Time of Death			
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	or Location of Death	reb c	4c. County of Dea	0			
	LAGITIII	Ŭ.	Sunrise Assis	ted Living		Sev	verna Par	k		Arundel			
	Funeral Director		5. Social Security Number 6. Sex 249–42–3362	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Apr. 9		thplace (State or Foreign ountry)			
	pu ,		Usual Residence of Decedent					Apr. 2	1323				
	shov	5	MD 10b. County Anne Ar		City, Town or Lo	severna I	Donale			10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
	28a-f	Director	10e. Street and Number	IIIGET	•	10f. Zip Code	ralk	1/	Og. Citizen of What Co				
	death with the Maryland ms 23a or 28a-f show		203 Oak Avenue				21146	"	US2	•			
	death	Funeral		12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of I	Hispanic Origin? (Spe van, Mexican, Puerto F	cify Yes or No-	14. Race - Ame	nican Indian,			
036	be filed within 72 hours after death with the Marylan dat Hygiana. All Hygiana. All Hygiana. All Hygiana. All Hygiana. All Hygiana. All Hygiana.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No		rican, etc.)	Black, Whit	_{e, etc.} Vhite			
1215-0036	nin 72 ho n "natur Vedicul	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	e completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of working	ng 1	16b. Kind of Business	Industry			
7.7	filed with Hygiene other the	mo.	Elementary/Secondary (U-12)	College (1-4or 5+)		Teache	er		Educ	cation			
<u> </u>	ba filed tal Hygi d other event, t	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle, Maiden Surname)					
<u> </u>		ို	George L. Kenned	<u>* </u>	_		Elizabet						
Maryland 2	d 2 sho		19a. Informant's Name/Relationship (Ty Russell Strother)				and Number or Rura. Nue, Severi		City or Town, State, MD 21146	_			
<u>က်</u>	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		20a. Method of Disposition		Place of Dispo	sition (Name of	D	ate 2	Town, State				
Baltimore,	permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other once.		1 ☐ Burial 2 🛣 Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)		Metro C	rematory or other pla	20.	Feb. 8, Baltimore, MD					
e B	Depar Mpor mpor mpor mny in		21. Signature of Funeral Service Licenses 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral										
	Physician /Medical Examiner	J	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	equence of):	ter the mode of dyi		r respiratory arre	rna Park, M	Approximate Interval Between Onset and Death			
,09	te be executed ysician and e burial-transit	I Examiner	Sequentially list conditions, I any leading to thin adiable cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse									
289	# × •	dlcal		J									
O. Box 6	The law requires that the death certificate ate has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	l3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3 [Ectopic pregnanc Other (specify)	у		23d. Date of del Month	ivery Day Year			
ds, P	uires that the de signed by the a ld be detached t	þ	Part II. Other significant conditions con	t II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tob.									
Ö	w requ	etec						24a. Was ar		obably 4 Onknown			
Vital Records,	The lav	Completed						autopsy	prior to death?	completion of cause of			
ita		Φ	25. Was case referred to medical				26. Place of Death			2□ No			
>	Physicien: this certifica al director, p	To B	examiner?	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatier	nt 3□ DQA Ott	nor		nce Cother (Spe	ASSISTED			
Division of	ktending Ph death. ctor: After th y the funeral		27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	ryat 2 rk?]Yes 2 □No	8d. Describe ho	w injury occurred	9,			
DIVIS	el or Attendes safter death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	reet, factory, office	2	8f. Location (Str City or Town,	reet and Number or Ru , State)	ıral Route Number,			
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Physical Control only 2 Medical Exemi	sician: To the best of my kr ner: On the basis of examir and manner stated.	nowledge, death nation and/or in	h occurred at the ti vestigation, in my o	ime, date and place, a opinion, death occurre	nd due to the ca d at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)			
	To the To the Comp	ž	29b. Signature and title of certifier			29c. Licens			d. Date signed (Mont				
	6		1 manegi	MD		15	7531	1	EB 07	2005			
1	3		30. Name and address of person of control of	ompleted cause of death (Ite	em 23a) (Type,	Print)	M.J.	le carrie	le non	21100			
	Sta	ate	31. Date filed (Month PB), Year 8 20	105 32. Anistrar's Sign	natur	berli	7,	-12016	le mo	- D			
	Dogiati		1 20 0 0 20	The state of the s	- /	-							

				State of Maryland / Dep	ertment of Health and Nertificate of Death		2005	03730
				Registrer 1. Decedent's Name (First, Middle, Last)	Timcale of Dealif	Reg.	N6. 0 U J	3. Time of Death
		Physici		IONE LARUE LAU SUMMERSON		Month February	6, 2005	8:30 A. M
		/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	rebluary	4c. County of Death	
	1	LXUIIII	101	Gilchrist Center	Towson		Baltimo:	
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth (Month, Day, Ye		place (State or Foreign intry)
	D.	Director		215-22-8303 ^{1 □ M 2} X̄F 81 Yrs.	Months Days Hours Min.	April 6,	1923 Peni	nsylvania
		p ≥		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	agation			
		show	2					10d. Inside City Limits 1 ☐ Yes 2 No
		h the Marylar or 28a-f show	Director	Maryland Baltimore Baltimor	10f. Zip Code	100	. Citizen of What Cou	
		with ta or	Dir	526 Dunkirk Road		109.		intry ?
		ns 23	Funerai		21212 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	U.S.A.	can Indian.
	9	ours after death with al', or items 23a or Examinate usi be		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No		Rican, etc.)	Black, White,	, etc.
	5-0036		d by	3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: Whi	ite
	5-0	d within 72 hours jiene. r than "natural", the Medical Exe	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ina 16t	b. Kind of Business/Ir	
Z	2121	within ene. than '	mpi	Elementary/Secondary (0-12) College (1-4or 5+)				
X		filed withi Hygiene. other than ant, the M		12 years 17. Father's Name (First, Middle, Last)	Homemaker 18 Mother's Nam	e (First, Middle, Maid	Own Home	
33 SAM	Maryland	be de la la la la la la la la la la la la la	Be				_	
2	Z	d 2 should th and Men 7 Is marke traumatic	7	Richard Henry Lau 19a. Informant's Name/Relationship (Type, Print) 19b. Maji	Vera La ing Address (Street and Number or Rur	rue Cook		n Cada)
	<u>≥</u>						aryland 21	
3	<u>o</u>			20a. Method of Disposition 20b. Place of Disp	osition (Name of		Location - City or T	
9	e E	Pages ent of tr. If I		1 A Burial 2 Cremation 3 Memoval from State	amatory`or other place) Memorial Park 2-8	8-05 Ba	altimore,	Maryland
9	Baltimore,	permit. Pages to Department of Hamportant: If the any injury or ot once.		FIGURATION	2 Name and Address of Facility			
_	ä	Depa fmpo any id		Thorsel Fierran	Mitchell-Wiedefeld	d Funeral Baltimore.	Home, Inc.	21212
0		N Test		23a. Part 1. Enter the lisease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
~1 .		Physician			sive Domenti	A		Onset and Death
9	7	/Medical		resulting in death) Due in (or as a consequence of):				- July
8		Examiner		Sequentially list conditions, b				
H.	J	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
C	V	be executional and purial-trans	Exan	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
B	8760	cate be execu physician and the burial-tra						
30	687	ficate physics the	edicai	d				
2	Вох	nding use a	N N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	erv
VM M	Ö.	death e atte	Physician/Me	in the past 12 months? 1	□Ectopic pregnancy □ Other (specify)		Month	Day Year
5	P.O.	at the by th tache	hys	9 □Unknown 9□Unknown				
R		es tha	by	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobacc	co use contribute to t	he cause of death?
V .)	ord	equir sen si ould		1). lated (Addisingop	THE TOTAL STREET	1 🗆 Yes	2 XTNo 3 □ Prot	oably 4 Unknown
	ecc	lawr as be	ompieted			24a. Was an autopsy	24b. Were auto	ppsy findings available impletion of cause of
	- H	The zate h page	Con			performed 1 ☐ Yes 2 ☑	l? death?	
	/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?		h (Check only one)		
	of	Physi this c	5	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie		me 5 Residence		y) forgice
	u C	ding I	lon	Natural 5 Pending (Month, Day Year) Injury	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	njury occurred	2.5
	Division of Vital Records,	death death ctor: y the	ertification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined determined		28f. Location (Street	t and Number or Rura	al Route Number
	Σ	after Dire	erti	4 Homicide determined building, etc. (Specify)	. Joseph Marton y, Gillion	City or Town, Si	tate)	ar riouto ivambor,
		spita hours ineral y filled	aic	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place,	and due to the cause	e(s) and manner as s	tated.
		To the Hospital or Attanding Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	ledicai	(Check only one) 2 Medical Examinar: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occur	red at the time, date	and place, and due to	the cause(s)
_		withi To t	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month,	
		/		· If Hydry Rily	in 0725	1	ebinary	6,2005
		Z		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) N. Cha	P= G :	Pac Of 11	1/2/201
		2)		31. Date filed (Month, Day, Year) 32. Registrar's Signature	0101 10.000	01 / 1	- CUT 200	· · · · · · · · · · · · · · · · · · ·
		Sta Registi		FEB 0 8 2005	hails !			
				FED O COOD JOSEP JO	4			

			1 - For State Registrar	State of Marylai	·		th and M	ental Hygi	ene nn5	03739
	Physici /Medio	al	Decedent's Name (First, Middle, Last,	P	SCARV	30 R O U	GN	2. Date of Death Month	λ 30, 200	
	Examin Funeral Director	er	The Tohns Hop 5. Social Security Number 213–58–1392	KINS HOSD	situl Be	HIMOR	LE CI	8. Date of Birth (Month, Day, 7/25/195	4c. County of Dea Year) 9. Bi CO Arc	nthplace (State or Foreign ountry)
	he Maryland 8a-f ehow offlied at	ector	Usual Residence of Decedent 10a. State 10b. County MD Harford]	ity, Town or Location					10d. Inside City Limits 1 ☐ Yes 2 XX No
	72 hours after death with the Maryland natural, or items 23s or 28s-f ehow disal Examinational be notified at	Funeral Director		12. Was Decedent Ever in L Armed Forces?		. Zip Code 21034 ecedent of Hispanic specify Cuban, Mex	o Origin? (Spe		g. Citizen of What C USA 14. Race - Am Black, Whi	erican Indian,
5-0036	72 hours afte natural', or it itsal Exercis	þ	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Ye	os 21 No Spec	ecify:	1	Specify: W	nite
nd 2121	il Hygiene. other then '	Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Homema	ruse retired) ker		(First, Middle, M	Own F	Iome
Maryland 21215-0036	d 2 should th and Men 7 is marks traumatic	ToB	Alfred P. Post 19a. Informant's Name/Relationship (Ty Lloyd H. Scarbo	pe, Print)		ress (Street and Nu 26, Darli	ımber or Rura		City or Town, State,	Zip Code)
Baltimore,	nit. Pages 1 and 3 artment of Heelth ortent: If Item 27 injury or other tr.		20a. Method of Disposition 1 X Burial 2 Cremation 3 P 4 Donation 5 Other (Specify)	20b. Da	Place of Disposition (cemetery, crematory)	(Name of or other place)	D	ate 2	Oc. Location - City or	Town, State Maryland
Bail	permit. Pag Department Importent: any injury o		21. Signature Funeral Service Licens 23a, Fart1. Easer the disease, or compl	Lovele	Harkin		lone, Inc		St.,Delta,	PA 17314
))	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	te cause on each line.	ACRANIAL quence of): USINOU		LENAG	t-		Interval Between Onset and Death 2 4 hours
Box 68760,	death certificate be executed e attending physicien and of for use as the bunal-transit	Physician/Medical Exa	in the past 12 months?	Due to (or as a consect of the conse	ancy	ic pregnancy			23d. Date of de Month	livery Day Year
ds, P.O.	as that the gned by th se detache	by	1	9□ Unknown			art I.	23e. Did toba		o the cause of death?
al Records,		Completed							prior to death? No 1 □ Yes	utopsy findings available completion of cause of
ion of Vital	Phys rthis ral dir	atlon; To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 D	04	Nursing Hom	(Check only one, ne 5 Residen 8d. Describe how	ce 6 □Other (Spe	cify)
Division		Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	(fy)			City or Town,		
	To the Hospitel or A within 24 hours after To the Funerel Direct completely filled in b	Medical	29a. Certifier Check only one) Contifying Physical Examination of Certifier Control on title of certifier Certifier Control on title of certifier Certifier	sician: To the best of my kniner: On the basis of examination and manner stated.	ation and/or investigat	tion, in my opinion,	death occurre	d at the time, dat	e and place, and due	to the cause(s)
j	1 1 8 1 8 A		30. Name and address of person who co	M.D.	m 23a) (Type, Print)	000	6244	8 7	ANU ARY	1. Day, Year) 30 \$ 2005
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 8 2005	22. Registrar's Sign	ature species	6 Struck	T , BA	MAIT VILE,	MD- 21	287

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Dr. John Albert Sweeney Feb. 3 2005 7:55 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1∏ M 2□ F Months Days Hours Yrs. Director 099-20-1694 79 June 3 1925 Ohio Usual Residence of Decedent 10a. State 10c, City, Town or Location 10b. County 10d. Inside City Limits 28e-1 show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 Acorn Circle, items 23a Apt. 101 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 411-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ þ 1 ☐ Yes 2 No Specify: 141-146 Specify: 3 Widowed 4 Divorced black naturel Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is 1 and 2 should be filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Professor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Sweeney, Sr. Alberta King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dereck Donovan/Son 20 Hallview Ct., Balto., MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iter
eny injury or oth 1 Burial 2 Cremation 3 Removal from State * 4 Donation 5 Dother (Specify) Garrison Forest Vet. Cem. 2/11/05 Garrison Forest, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Appropriate Cause (State Cause (State Caus Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SNOKES months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events Examine certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) attending physician Box 68760 Physician/Medical the IF FEMALE nse . 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) P.0. the Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? page 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Hospitel or Attending 1 Natural 2 Accident Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifie und 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 8 2005 Registrar

			for State Registrar	State of Ma	ryland / De	partment of I ertificate of	Health and	Mental Hy	giene.	0.55	037	41
	Dhysiai		1. Decedent's Name (First, Middle					2. Date of De Month	ath Day	Year	3. Time of D	eath
	Physicia /Medic		Lillian F. Sp	oicer				02/06	/2005	1001	0915	М
	Examin	er	4a. Facility Name (If not institution				or Location of De	ath	4c. County	of Death		
			Future Care - 5. Social Security Number			Baltin	nore If Under 24 H	rs o Data at Gird		0.011		
	Funeral Director		218-01-5259	1 □ M aNE	(In yrs. last birthda 66 Yrs	Months Days			y Year)	Country	ce (State or I	Foreign
~ -			Usual Residence of Decedent					10/03	7 1 3 1 0	Mary	land	
	72 hours after death with the Maryland naturel', or Items 23s or 28s-f ehow deat Exame of must be molified at		10a. State 10b. County		10c. City, Town or	Location				100	d. Inside City	Limits
	be filed within 72 hours after death with the Marylan ital Hygliene id other than "naturel", or flems 23a or 28a-f show avent, the Marical Exambat must be notified at	Director	Maryland Howa	ard	Ellicot	t City					1 Tes 2	2 No
	or 28	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country	y?	
	ath w	rai	2397 Ballard	Way		21042			United	Stat	.es	
	er de	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S. 1	Was Decedent of I If Yes, specify Cub	Hispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Rae Bla	ce - American		
36	s afte	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 🛣 Divorced	If Yes, Give	0	1 ☐ Yes 2 📉 No			Specil	v:		
21215-0036	hour turel	edt	15. Decedent	Year or Dates:	16a De	cedent's Usual Occup	nation		16b. Kind of B	Whit		
15	n ne	piet	(Specify only highes	st grade completed)	(G	ive kind of work done . DO NOT use retire	during most of w	vorking	TOD. KING OF E	dalileas/IIIdu	Sily	
212	iene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	retary			Busni	ess		
ğ	e filed Il Hygi other vent, t	Be C	17. Father's Name (First, Middle,	Last)			18. Mother's N	lame (First, Middle,	Maiden Sumar	пө)		
<u>la</u>	should be ind Mental Ind Marked o	ToE	Felix Kalicir	nska			Paulin	e Klono	wska			
Maryland	s 1 and 2 should f Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relations	hip (Type, Print)	19b. M	ailing Address (Street				State, Zip C	ode)	11
	and 2 salth n 27 I er tre		William H. Sp	oicer - Sor		7 Ballar		Ellicot	t City	, MD	21042	2
ore	A 0 .		20a. Method of Disposition 1 □ Burial 2 🌠 Cremation	3 DRemoval from State	20b. Place of Dis cemetery, of	sposition (Name of crematory or other pla	ce)	Date	20c. Location	City or Town	n, State	
Ĕ	Pages ment of I ant: If Its ury or o		'4 □ Donation 5 □ Other (S	pecify)	Bayview	Cremato	ry 02	/08/200	5 Balt	imore	, MD	
Baltimore,	permit, Page Depertment of Important: If any injury or once.		21. Signature of Funeral Service	Licensee // /	1-0	22. Name and Address David J.	ss of Facility Weber	Funera	l Home	s P A		
	707 e a		Mathlein	U. Weber			mason	-Avenue	Datel	mor – -	1,10	2122
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lin	the death. Do not e.	enter the mode of dyi	ng, such as cardi	iac or respiratory a	rrest,	l r	Approximate nterval Betwe Onset and De	
	Physician		Immediate Cause (Final disease or condition resulting in death)	- PNEU	MONI	IA					711361 ANG DE	70.01
	/Medical Examiner		rosaking in doakiny	Due to (or as a	a consequence of):	4						
		-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequence of):	4						
	uted Insit	H L	Cause (Disease or injury									
Ć.	exection and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):				-			
8760,	The law requires that the death certificate be executed ite has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	ical		d								
9	ntifica ng ph as th	ed	IF FEMALE:									
Вох	eath certific attending pl	an/h	23b. Was decedent pregnant	23c. If yes, outcome		3 Ectopic pregnanc	·v			te of delivery		
-	at the dea by the at tached fo	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 Other (specify)			Me	onth D	ау Үө	ar
P.0	d by detach		Part II. Other significant condition	one contributing to death by	at not conditing in th	a undachina causa su	una in Dant I	220 Did t	obacco use con	taibusta ta tha	saves of da	a4b2
Vital Records,	ires that signed b	l by	PARK	SINSONIBULING TO GREAT DE		Marying cause gr	rem im Fauti.	1 🗆 1			oly 4 🗆 Un	
Ö	w require been sig should b	ete										
Rec	The lav ate has page 2	Completed						24a. Was autop	osy	Were autops prior to comp death?	y findings av pletion of cau	ise of
a		e Co	25. Was case referred to medical					1 ☐ Yes	2 No		□ No	
Ē	Physicien: this certific ral director,	0	examiner?	Hospital:	nt 2 ER/Outpa	tient 3 DQA	_	eath <i>(Check only o</i> Home 5 Resid		(C/t-)		
of	g Ph) er thi	Ë	27. Manner of Death	28a. Date of Injur		e of 28c. Inju			now injury occur			
<u>o</u>	Attending F r death. actor: After by the funer	atio	1 Natural 5 Pendin 2 Accident investig		Year) Injur		rk?]Yes 2 □ No					
Division	ol or Attendir after death. I Diractor: At d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could of determ	not be ined 28e. Place of Inju- building, etc	iry - At home, farm,	street, factory, office		28f. Location (S City or Tov	Street and Numi	ber or Rural F	Route Numbe	er,
	Itel or irs after rel Dira	Cer										
	To the Hospitel or vithin 24 hours after To the Funerel Dirac completely filled in b	ical	Check only 2 Medical	g Physician: To the best of Examiner: On the basis of	examination and/o	eath occurred at the ti	me, date and pla opinion, death oc	ce, and due to the curred at the time.	cause(s) and m	anner as stat	ed. ne cause(s)	
	To the within 2 To the complet	Medical	one) 29b. Signature and title of certifie	and manner sta	ted.	29c. Licens			29d. Date signe			
	5 ₹ ¥ ₹ 5		1.1. Utt.	1	~				200. Date signe	7	17, 10al)	
	,		30. Name and address of person		ath (Item 23a) (Tu		23451	U ,	L-	1-0	>	
1	5		WAR TWA	TER WEN N	LD 590	I Coma	CH LA	/tes	EX 71	052	-	
	Sta	te	31. Date filed (Month, Day, Year)	32. egistra	r's Signature	Gode				- 0 -		
	Registr	ar	FEB 0 8	3 2005 Decem	J. J. J.	SHIP TO						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death (First Middle Last) 2. Date of Death cedent's Name 3. Time of Death Month Day Year Physician 0805A M /Medical Fourth 2005 Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death **Examiner** . Age (In yrs. last birthday) Social Security Number **Funeral** Birthplace (State or Foreign Country) Months Days 1 □ M 2 🔀 F Director the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic avant, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director Street and Number 10g. Citizen of What Country? 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married ☐Yes 2XNo Yes. Give Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 □ Divorced Year or Dates "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working ide DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) is marked othar permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked ofth any njury or other traumatic avant. ODES. 17. Father's Name (First, Middle, Last) Be Ston. lones 19b. Mailing Address (Street and Nu Informant's Name/Relationship (Type, Print) Method of Disposition

■ Burial 2 □ Cremation 3 DRemoval from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician a. bestrointestine hours /Medical Due to (or as a consequence of). **Examiner** tremic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital of Attending Physician: The law requires that the death certificate be executed シレン Box 68760 Due o (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 1 Inpatient 1 🗌 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred After 1 Natural 5 Pending investigation dealth. 1 Yes 2 Accident , after death in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Joselyne KounteHOLL AT2438946 LT

Registrar
DHMH 17 Rev 1/2001

le

State

JOCELYNE

31. Date filed (Month, Day,

201 East University Parkwey, Bultimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

KO ALL A TCHOU

8

Year

February fouth 2005

MD

			For	State of M	laryland / Dep			Mental Hy		00710
			1 - Stete Registrar 1. Decedent's Name (First, Middle	, Last)		rtificate of	Death	2. Date of De	Reg. No. 005	3. Time of Death
	Physici /Media	cal	VVIAV	3 540	NOR	1		FEBRU	imp 5 2001	-0748 M
	Examir	ier	4a. Facility Name (If not institution NO A TH WE		PITAL	4b. City, Town, or	ALIST	OWN	4c. County of Dea	IMORE
	Funeral Director		5. Social Security Number	6. Sex 1 ☐ M 22 F 7. A	ge (In yrs. last birthday, Yrs.	Months Days	If Under 24 H		rth ay, year) 24	rthplace (State or Foreign ountry)
	anyland ehow	7	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	th the M or 28a-f e natifie	Director	10e. Street and Number	NA		10f. Zip Code	more		10g. Citizen of What C	1 ✓ Yes 2 □ No ountry?
	death wi	Funeral L	2953 11 Orna 11. Marital Status	f Kead /	t Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	1209 ispanic Origin?	Specify Yes or No	USH 0- 14. Race - Am	erican Indian,
39	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygjene, item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Examination and be notified at	by Fur	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	Armed Forces ed 1 Yes 2 If Yes, Give / Year or Dates:	No	If Yes, specify Cuba 1 ☐ Yes 2 No	n, Mexican, Pue Specify:	rto Rican, etc.)	Black, Whi	
21215-0036	n 72 hou "nature	ieted	15. Decedent (Specify only highes	's Education	16a. Dece	dent's Usual Occup		orkin g	16b. Kind of Business	/Industry
	filed within Hygiene. Other then ont, It e M	Completed by	Flementary/Secondary (0-12)	Gollege (1-4or 4 YRS	5+)	chind of work done of DO NOT use retired	eacher		Batto. Cit	4 Public School
Maryland	should be filed with ind Mental Hygiene. I marked other than umatic event, ILE M	To Be	17. Father's Name (First, Middle, I	rchill			18. Mother's No Helen	Robin	, Maiden Surname)	J
	nd 2 sho alth and I 27 is mu		19a. Informant's Name/Relationsh	or Thomas (De	2htr) 7724	ng Address (Street a	and Number or F	Hanover	er, City or Town, State,	Zip Code)
ore,	Pages 1 and 1 nent of Health ont: if item 27 iry or other tr		20a. Method of Disposition 1 🗆 Burial 2 🗷 Cremation	3 □Removal from State	, /	matory or other plac	10/	Date	20c. Location - City or	
Baltimore,	parmit. Pages 1 and Department of Health importent: if item 27 any injury or other tr once.		`4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L		Greenme	DURE ("I' EMO 2. Name and Addres	ton 2-9	aughn c	Greene Fu	neral snc.
	207		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cause	d the death. Do not en	728 Lube	evity Kol	. Randa	Ustown, M	D 2/133 Approximate
	Physician		shock, or heart Tailure. List of Immediate Cause (Final disease or condition resulting in death)		STAGE			IOPATI		Interval Between Onset and Death
	/Medical Examiner			Due to (or as	s a consequence of):		cvo			
V	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		s a consequence of):					
8760,	rate be executed physician and the burial-transit		resulting in death) Last	Due to (or as	s a consequence of):					
9	intificate ing phys a as the	Medical	IF FEMALE:	d						
О. Вох	The law requires that the death cartificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
ds, P	ires that signad b	by	Part II. Other significant condition	ns contributing to death t	out not resulting in the u	nderlying cause give	en in Part I.		obacco use contribute to	_
ecor	aw requir as been si 2 should	Completed						24a. Was	an 24b. Were au	utopsy findings available
Vital Records,		e Com	25. Was case referred to medical					1 Tes	omed? death? 2 Gro 1 ☐ Yes	2 DAY
of Vii	hysic his ce il direc	To B	examiner? 1 Tes 2 XX	Hospital: 1 Papati				eath <i>(Check only o</i>	dence 6 □Other (Spe	cify)
ion	nding P ath. r: After t	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investig.		ury 28b. Time of Injury	Work	at ?? Yes 2 □ No	28d. Describe I	how injury occurred	
Division	Hospital or Attending P 4 hours after death. Funeral Director: After tely filled in by the funera	Certification:	3 ☐ Suicide - 6 ☐ Could n 4 ☐ Homicide determin	28e. Place of In building, e	jury - At home, farm, str tc. (Specify)	eet, factory, office		28f. Location (S City or Tox	Street and Number or Ri wn, State)	ural Route Number,
	Hospita 4 hours Funera ely fille	ledical C	29a. Certifier 1 Certifying (Check only one) 2 Medical 8	Physician: To the best xeminer: On the basis of and manner st	A Grannilation and of in	h occurred at the tim vestigation, in my op	e, date and place sinion, death occ	e, and due to the curred at the time,	cause(s) and manner as date and place, and due	s stated. to the cause(s)
	To the within 2.	Me	29b. Signature and title of certifier	Λ ο.	0 0	29c. License			29d. Date signed (Mont	
	. ^		30. Name and address of person w	no completed cause of	death (Item 23a) (Type,	Print)	717	> >	FEBRUA	12,6001
	IU		31. Date filed (Month, Day, Year)	1 Mo.	NHC ,	Print) ALTI	D. MI	115	53	
	Sta Registr	-		8 2005	STARL H.	Soule				

Zachary Scott 05-00948 RJ

Certificate of Death Discording Hamman (Fort, Motion, Lase) To Deader's Hamm				for State	tate of Maryland / [ental Hygier	ne No o E	0271.1.
The property of the property o				Registrar		Certificate of L	Death	0.0-11011		03/44
The first water of from entitioner by great each number of the controlled of the con					1 Snorth			Month [Pay 2005	
State South Search Personal Contro				20,0,00,0	et and number)	4b. City, Town, or	Location of Death	rebruiry	4c. County of Death	
The Green of March 1990 In the Country Information Country Informa				1212 Walker Avenue,	Apartment C	Baltim	ore			NIA
The State of the S				000 11		Months Days		8. Date of Birth (Month, Day, Yea	9. Birth Cou	place (State or Foreign ntry)
The property of the property o				220-09-0100		113.		6-8-5	ł	IND
The property of the property o		how	_	10a. State 10b. County	10c. City, Town	n or Location				/
The property of the property o		he Ma	ecto	mb	NA	50	lltumore			
The property of the property o		with t	Dir		10 10 #P	10f. Zip Code	1120	10g. (Citizen of What Cou	ntry?
The property of the property o		death ims 2%	nera		Was Decedent Ever in U.S.	13. Was Decedent of Hi	spanic Origin? (Spe	cify Yes or No-		
The property of the property o	20	or Ite		,	1 □Yes 2 ☑ No If Yes, Give	1		Rican, etc.)	0.	etc.
The property of the property o	ş	hours ture!	ed b			Decedent's Usual Occupa	tion	16h	L OI	ACK
The property of the property o	212	hin 72 9. 8n "ne	piet	(Specify only highest grade co	mpleted)	(Give kind of work done a	uring most of working	ng los.	. All .	. #
The property of the property o	7	lygien lygien her th		12th GRADE	2 yrs	Budget A	nalyst		hn Hopku	ns Husp.
230. Magned of Disposition (Name of Disposition) (Name of Disposit	and	e d la b	8	Central (First, Middle, Last)		9			len Sumame)	•
230. Magned of Disposition (Name of Disposition) (Name of Disposit	ary	shoul	ř	19a. Informant's Name/Relationship (Type,	Print) 19b.	. Mailing Address (Street a			y or Town, State, Zij	o Code)
2 10 5 5 5 5 5 5 5 5 5		and 2 saith a n 27 is		Michelle Y. Scott	Daughter) 27	763 The Al	ameda t	Baltimore	MD 2	21218
Physician Medical Examiner Physician	ore	0 0			comotos	Disposition (Name of v. crematory or other place	9)	ate 20c.	274.1	58394
Physician Medical Examiner Physician	<u>=</u>	it. Pa irtmen irtent: njury			Kung'					
Physicial Medical Examiner Physicial Residence of the Medical Examiner Physicial Residence of the Medical Examiner Physicial Ba	Department Department		200 John Call			VU VU			rai service	
Physician Medical Examiner The past propose of program of the past 12 months? The past 12 m				23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of	ons that caused the death. Do r				ريار, دس	Approximate Interval Between
Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Teasiling in death). Last IF FEMALE. 23c. Was decedent pregnant in the Day Year Cause (Disease of Injury Cause Cause. Enter Underlying Cause. Enter Underlying Caus				Immediate Cause (Final disease or condition	-1 0 11	200		4.7	£	Onset and Death
The part of the pa				resulting in death)	Due to (or as a consequence of	of):		01/01/		
Section Color Co	ļ		Jer	If any leading to immediate	Dua to (or as a nonsequence	J)+				
Section Color Co		scuted ind transit	amir	Cause (Disease or injury that initiated events						
FFEMALE: 23d. Date of delivery 23d. Date of legical 23d. Date of delivery 23d. Date of legical 23d. Date of le	ęç,	be exi		resulting in deathy cast	Due to (or as a consequence of	of):				
State State	/89			d						
State State	ŏ	th cert ending r use	an/M	23b. Was decedent pregnant 23c.		3 Dectonic pregnancy			23d. Date of deliv	ery
The part is significant contributes contributes to the cause of death? 1 Yes 2 No 3 Probably 4 Inchings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Inchings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Inchings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Inchings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Inchings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Inchings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Inchings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Inchings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Inchings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Inchings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Inchings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Inchings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Inchings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Inchings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Inchings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Inchings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Inchings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Inchings available prior to complete of cause of death? 1 Yes 2 No 3 Probably 4 Inchings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Inchings available prior to complete of cause of death? 1 Yes 2 No 3 Probably 4 Inchings available prior to complete of cause of death? 1 Yes 2 No 3 Probably 4 Inchings avail		0 0	/sici	1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death				Month	Day Year
25. Was case referred to medical examiner? 1	٦.	that the			uting to death but not resulting in	n the underlying cause give	n in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
25. Was case referred to medical examiner? 1	rds	quires an sign uld be	d pa	DIANETES MET	MINS			1 🗆 Yes	2 □ No 3 □ Prol	pably 4 Unknown
25. Was case referred to medical examiner? 1	000	faw reas bee	plet					24a. Was an	24b. Were auto	ppsy findings available
The state of the s	Y E		Con					performed	death?	
5 State State OCME Journal OCME February 6, 2005 Journal of Completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201	\ <u>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</u>	sicien certifi	8	examiner?	pital:	Othe	_			
5 State State OCME Journal OCME February 6, 2005 Journal of Completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201	O	g Physer this eral d	-	27. Manner of Death	8a. Date of Injury 28b. T	thatterit 2 DOX	4 Nursing non			y) At scene
5 State State OCME Journal OCME February 6, 2005 Journal of Completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201	SION	ending sath. or: Aft he fun	atio	2 Accident investigation	(Month, Day rear)					
5 State State OCME Journal OCME February 6, 2005 Journal of Completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201	Š	or Att	ertific		Be. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	2			al Route Number,
5 State State OCME Journal OCME February 6, 2005 Journal of Completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201	_	spitei		29a. Certifier 1☐ Certifying Physici	an: To the best of my knowledge	, death occurred at the tim	e, date and place, a	nd due to the cause	(s) and manner as s	tated.
5 State State OCME Journal OCME February 6, 2005 Journal of Completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201		the Ho in 24 t the Fu pletely	ledic	(Check only 24 Medical Examiner	On the basis of examination and	d/or investigation, in my op	inion, death occurre	d at the time, date a	and place, and due t	o the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 State 31. Date filed (Month, Day, Year) 32. Tegistrar's Signature		To To	2	29b. Signature and title of certifier	()/ .00 -					
State 31. Date filed (Month, Day, Year) 32. Tegistrar's Signature (Month, Day, Year) 32. Tegistrar's Signature (Month)		1		30. Name and address of person who come	leted cause of death (Item 23a) (100)	<u> </u>	Fel	bruary 6,	2005
State Registrar State Registrar State FEB 0 8 2005 32. Fegistrar's Signature Registrar		2		MARGAMOS	B. KOREL		n Street	Baltimore	, Marylan	d 21201
				31. Date filed (Mohth, Day, Year) FEB 0 8 2005	32. registrar's Signature	Sparke				

			1 - For State Registrar	State o	f Marylar		artmer <i>rtificat</i>				/lental Hy	gien	0.01	0371	15
	Dhusisi		1. Decedent's Name (First, Middl	e, Last)							2. Date of D	eath Da	v	3. Time of	Death
	Physici /Medio		Barbara Wal	lace Slagh	nt						Februa	ry :	ay Year 3 200!		М
	Examir		4a. Facility Name (If not institution	n, give street and nur	mber)		4b. City,	Town, or	Location	of Death	•	40	c. County of Dea	ath	
			Carroll Hospita	al Center			Wes	tmins	ster			C	arrol1		
	Funeral		5. Social Security Number		7. Age (In yrs.	last birthday)	If Under	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth		rthplace (State or	<i>Foreig</i> n
	Director		215-22-2852	1□M 2⊠F	7	7 Yrs.	NOTITIES	Days	Hours	IVIII I.	March	2, 1	927 Mar	yland	
	Du .		Usual Residence of Decedent 10a. State 10b. County		10- 0	ty, Town or Lo									
	eho eho	5			100. 01	ty, TOWN OF LC	cation							10d. Inside Cit	•
	8e-f	ctc		imore		Randa								1 🗆 Yes	2 <u>X</u> _] N0
	vith ti	Director	10e. Street and Number				10f. Zip					10g. Ci	itizen of What C	ountry?	
	be filed within 72 hours after deeth with the Maryland that Hyglene. ad other then "naturel", or iteme 23a or 28e-f ehow event, the Mayleal Examiner must be nutified at	Funerai	3521 Kings Po						21133				U.S.A.		
	item	une	11. Marital Status	Armed Fo		l.S. 13.	Was Dece If Yes, spe	dent of His cify Cubar	spanic Ori n, Mexicar	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Am Black, Whi		
9	s aft	by F	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes Giv	/e		1 🗆 Yes	2 √ No	Specify:				Specify:		
12-003p	hour turel			t's Education	ates.	16a. Deced	dont's Hay	al Ossupa	tion			100 1	Clark at Devices	White	
Ċ	in 72	Completed	(Specify only highe	st grade completed)		(Give	kind of wo	rk done di se retired)	uring mos	t of work	ain g	160. F	Kind of Business	Vindustry	
<u> </u>	with ene.	mc.	Elementary/Secondary (0-12)	College (1	1-4or 5+)		emake					١.	Own Hom	Δ	
0	a filed within 72 hours after I Hygiene. other then "naturel", or Ite rant, the Medical Exprime	a)	17. Father's Name (First, Middle,	Last)		1			18. Mothe	er's Nam	e (First, Middle	_			
	ental ked o c eve	ToB	Benjamin Walla	ace							Caster		,		
2	2 should be and Mental is marked of reumatic eve	-	19a. Informant's Name/Relations			19b. Mailir	ng Address	(Street a		-			or Town, State,	Zin Code)	
Mar	Ith all		Robert J. Slagh		ind)									yland 21	133
ā,	f Heal		20a. Method of Disposition		20b. I	Place of Dispo	sition (Na	ne of			Date		ocation - City or		133
2	ages ant of it: If I		1 Burial 2 Cremation 4 Donation 5 Other (S		State	cemetery, cren			1	0 1/	0005				
Бант	artme orten injur		21. Signature of Funeral Service		Ga	rrison			of Facilit	Z-1(0-2005	OWI	ngs Mil	ls, MD	
ñ	permit. Pages 1 and 2 should b Department of Health and Menta Importent: If Item 27 is marked any injury or other treumatic a <u>once</u> .		1/1/1/1/1	6 1	1	16	litzk	Fun	eral	Hom	e of Ca	ton	sville,	Inc.	0.00
			23a Part1. Enter the disease, or shock, or heart failure.	implications that c	aused the deat	th. Do not ent	er the mod	e of dvina	such as	cardiac	or respiratory a	rrest.	ie, Mar	yland 21	
	D		shock, or heart failure.	only one cause on e	ach line.	4		1						Interval Betw Onset and D	reen
	Physician /Medical		disease or condition resulting in death)	a. Due to	or as a consec	1014	aci	0051	5						
	Examiner			Due to () as a consec	A * (4							harlet		
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq	uence of):							many	year J	
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	S											
ĵ	exec an an iai-tr	Еха	resulting in death) Last	Due to (or as a conseq	uence of):									
0 / p	certificate be executed riding physicien and use as the burial-transit	dicai		d											
Q Q	tifical g ph as th	ledi													
ŏ	leath certific attending p	N/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna		7c-+:	2211					23d. Date of de	livery	
מ	0 0 0	icla	in the past 12 months?	4☐Pregn	ant at time of d		Ectopic pr Other (sp						Month	Day Y	ear
j.	oy th ache	Physician/Me	9 Unknown	9□ Unkno	own										
,	w requires that the sbeen signed by the should be detached	ру Р	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the ur	nderlying c	ause give	n in Part I.		23e. Did 1	obacco	use contribute to	the cause of de	ath?
coras	equire en siç ould b	ed									1 🗆	Yes 2	□Mo 3 □ Pi	robably 4 🗆 Ur	nknown
0 0 0	> 0 5	piet									24a. Was		24b. Were at	utopsy findings a	vailable
r	Physicien: The lav this certificate hes al director, page 2	Completed			/							rmed?	death?	completion of car	use of
	en: tifica tor, p	a	25. Was case referred to medical						26 Place	of Deatl	1 Yes	2 No	1 Tes	2 □ No	
>	Physicien: this certific ral director,	OB	examiner? 1 Tes 2 No	Hospital:	npatient 2	ER/Outpatien	t 3 🗆 DC	Other	~				6 Other (Spe	cifu)	
Ö	g Ph er th eral	n: T	27. Manner of Death	28a. Date of	of Injury h, Day Year)	28b. Time of Injury		8c. Injury Work			28d. Describe			ony)	
0	ath. r: Afi	atio	1 ■ Natural 5 □ Pendin 2 □ Accident investig	gation	n, buy roury	Hijury	М		es 2 🗆 f	No					
UNISION	Atte	tific	3 Suicide 6 Could determ	ined 286. Place	of Injury - At h	ome, farm, stre	eet, factory	, office			28f. Location (City or To			ural Route Numb	e <i>r</i> ,
5	s aft	Certification:		ound.	ig, etc. (opacii	,,					Only of 10	wii, State	7)		
	To the Hospitel or Attending Ph within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifyin	g Physician: To the Examiner: On the ba	best of my kno	wledge, death	occurred	at the time	e, date and	d place,	and due to the	cause(s) and manner as	stated.	
	the H in 24 the F iplete	ledicai	one)	and mann	ner stated.		restigation	in my opi	nion, deat	in occurr	ed at the time,	date and	d place, and due	to the cause(s)	
	To To	Σ	29b. Signature and title of certifie					. License				29d. Da	te signed (Mont	h. Day, Year)	
	0						1	000	250	673	8	Fek	recary	4,20	05
	'5		30. Name and address of person	who completed caus	e of death (Iten	п 23а) (Туре,	Print)							*	
			HOY J.	Carls,	M.D.		91	Ston	ev	Ave	. Su	ite	204 4	14,20 Vestmi	1ster
	Sta	-	31. Date filed (Month, Day, Year)	8 2005 D	egistrar's Signa	iture	Acres	0 0							
	Registr	ar	LED A	0 7007	A. 675 J	No A	200								

S			1 - For State of Maryland / Dep	artment of Health and Mertificate of Death		ne N2005	0371.6				
	Discosio		Decedent's Name (First, Middle, Last)	Timodic of Bedin	2. Date of Death		3. Time of Death				
	Physicia /Medid	al	THOMAS F. STIPA, JR.			² 4, 2005	1742 p ^M				
	Examin	er	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital	4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A					
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday).		8. Date of Birth (Month, Day, Yea		place (State or Foreign				
	Director		216-82-4724 1		4/23/196		/LAND				
	ryland how		10a. State 10b. County 10c. City, Town or L	ocation		1	0d. Inside City Limits				
	8a-fs	Director		RKVILLE			1 ☐ Yes 2 ☐XNo				
	ier death with the Marylan Itams 23a or 28a-f show Let must be rediffed at		10e. Street and Number 8116 DALESFORD ROAD	10f. Zip Code		Citizen of What Cour	ntry?				
	death	Funerai		21234 Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F		USA 14. Race - Americ					
36	72 hours after death with the Maryland natural, or Itams 23a or 28a-1 show Jisal Evarul at must be notified at	by Fu	1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	nicari, etc.)	Black, White, Specify:					
9	natural',	ted t	15. Decedent's Education 16a. Dece	edent's Usual Occupation	16b.	. Kind of Business/Ind	/HITE dustry				
215	within 7. ene. than "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Giv.	a kind of work done during most of workir DO NOT use retired)	ring most of working						
27	filed w Hygier othar th		12TH GRADE TRU 17. Father's Name (First, Middle, Last)	CK DRIVER	(First, Middle, Maid	SEAFOOD					
Maryland 21215-0036		To Be	THOMAS F. STIPA, SR.	BARBARA		ion comame,					
lary	2 should be and Mental is markad aumatic sv		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rura		ry or Town, State, Zip	Code)				
	s 1 and of Health itam 27 other tr				TIMORE, MI	D 21234 Location - City or To	uum Ctoto				
Baltimore,	0 0			osition (Name of matory or other place) EMATORY, INC. 2/8/2		ONSVILLE,					
altir	교원관금 .			2. Name and Address of Facility THE							
ä	permi Depa Impo any ii			521 LOCH RAVEN BLVI		, MD 2128	6				
			233 Part Emer the disease, or conplications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final	nter the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death				
	Prysician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	aum	77						
	Examiner		Entune 1	left Went in	cle						
	led nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a Diulant	TIM)						
Ć.	be executed sician and burial-transit	Examine	that initiated events resulting in death) Last c. Due to (or as a consequence of):	of warce							
8760,	ate be executed hysician and the burial-transit	dicai	d				<u>-</u>				
9		/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			2015 1015					
Box	death certific e attending p ed for use as	Physician/Med	1 Live birth 2 Fetal death 3 in the past 12 months? 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	Day Year				
P.0	that the de	Phys	9 □ Unknown								
Ś	es be	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	ably 4 Dunknown				
Vital Record	> 0 50	Completed			24a. Was an		psy findings available				
Re	he he h	omp			autopsy performed1 1⊠Yes 2□1	prior to cor death?	npletion of cause of				
/ita	ician: T certificat rector, pa	Bec	25. Was case referred to medical examiner?	26. Place of Death	1						
of	Phys this ral di	1. 70	1 (2X) es 2 □ No		ne 5 Residence 8d. Describe how in	6 ☐Other (Specify	1)				
	Attanding For death. actor: After by the funerations	ation	1 Natural 5 Pending (Month, Day Year) Injury	of 28c. Injury at 2 Work? M 1 Yes 2 No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
Division	tal or Attandii s after death, al Diractor: A ad in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	treet, factory, office 2	8f. Location (Street City or Town, Sta	and Number or Rura ate)	l Route Number,				
Ω	E 5 E E		29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, dea	the accurred at the time date and place a	and due to the second	(a) and manage on st	atod				
	To the Hos within 24 ho To the Fund completely f	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurre	d at the time, date a	and place, and due to	the cause(s)				
	To th withir To th comp	Me	29b. Signature and title of certifie	29c. License number		Date signed (Month,					
•			AIUU	OCME	Fel	bruary 5,	2005				
1	2		30. Name and address of person who com Hed cause of death (Item 23a) (Type	111 Penn Street	Baltimore	e MD 21201					
*:	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature								
	Registr	ar	FEB 0 8 2005 Beaus 15	Soule							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#16b, perFh, C840.2/8/05 TT
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FEB. **ELLIOT** SCHREIDER 2005 3:30 A M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE 6. Sex 10 M 2 ☐ F 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Director 014-20-6440 MA Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner must be notified at Director BALTIMORE BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3200 OLD POST DRIVE APT. #5 21208 U.S.A. Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 XIYes 2 □ No WW II If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PURCHASING MANAGER 4 VITRO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JACOB SCHREIDER JANE HOROVITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ages 1 and 2 st tof Health and : If item 27 Is n EUNICE SCHREIDER / WIFE 3200 OLD POST DRIVE APT. #5 BALTIMORE, MD 21208 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State OF place) LIBERTY ZABK 5 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. *4 □ Donation 5 □ Other (Spacify) 02/06/2005 RANDALLSTOWN, MD re of Fune al Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. icens 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part . Enter the disease, or shock, or heart failure. List only licitions hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Hepatocellular
Due to (or as a consequence of): Physician Carcinona montas /Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit Due to (or as a consequence of): .O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death signed by the at d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 Yo Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation M 1 Yes 2 No after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Thomicide 24 hours a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 4 2005 052303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ADD CHALUS NO Exc N. Charles St Baltware M 2/204 32. Resistrar's Signature 31. Date filed (Month, Day, Year) FEB 0 8 State 2005 Registrar

		,	For State Registrar	State of Marylan		artment of H			giene 00	5 03748			
ı	Physici		Decedent's Name (First, Middle, La. GEORGE	st)	ST	LVER		2. Date of De		3. Time of Death 10:30 P M			
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or			4c. County of D	Death			
	Funeral		RUXTON PIKESVIL 5. Social Security Number 6. S			PIKESV If Under 1 Year	If Under 24 H	rs. 8. Date of Birt	BALTIM(Birthplace (State or Foreign			
	Director		216-14-7079 ¹	X ^{M 2□F} 84	Yrs.	Months Days	Hours Mi	s. B. Date of Birt in. SEPT. 30	j,1920	Country) NY			
	yland		10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits			
	he Ma	ector	MD BALT	IMORE	BALT	IMORE			40 000	1 ☐ Yes 2 No			
	h with	al Dir	ONE POMONA EAST	#409		10f. Zip Code	21208		10g. Citizen of What	USA			
	er deat Items	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.			
5-0036	n 72 hours after death with the Maryland "netural", or Items 23a or 28a-f show calcal Expr unarrhant be rediffed at	by	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 MYes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify:	WHITE			
15-0	n 72 h	ietec	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of w	vorking	16b. Kind of Busine	ess/Industry			
2121	led within 'tygiene.'	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	MS EXAMIN	•		VETERANS	ADMINISTRATIO			
Maryland	be fi	To Be	17. Father's Name (First, Middle, Last) NATHAN		SILV	FR	18. Mother's N	ame (First, Middle,	Maiden Sumame)	KREBS			
lary	2 should and Men Is marke eumetic	-	19a. Informant's Name/Relationship (19b. Mailir	ng Address (Street a	and Number or		er, City or Town, Stat	e, Zip Code)			
	ges 1 and 2 t of Health if Item 27 or other tro		SHIRLEY SILVER A			PUMUNA EA sition (Name of natory or other place		Date	MORE, MD 2 20c. Location - City				
altimore,	Pages ment of mury or o		1 X Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 3 ☐ Other (Specification)					06/2005		RSTOWN, MD			
Balt	permit. Page Department of Important: If any injury or once.	OSOU KEISTEKSTUWN KUAD - PIKESVILL											
	23a. Part. Enter the disease, or complications the caused the death. Do not enter the mode of thing, such as cardiac or respiratory arrest. Physician /Medical Physician /Medical Due to (or as a consequence of):												
L	Examiner	_	Sequentially list conditions,	b. Due to (or as a consequ	uonan afli								
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C	denos ory.					ſ			
8760,	icate be executed physician and s the burial-transit	dicai Ex	resulting in death) Last	Due to (or as a consequ	uence of):								
.O. Box 687	aath certif attending for use a	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna Live birth 2 Fetal Pregnant at time of do	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year			
Д.	quires that the d n signed by the uld be detached	þ	Part II. Other significant conditions of	ontributing to death but not resu	1		en in Part I.	23e. Did to		e to the cause of death?] Probably 4 □Unknown			
Vital Records,		Completed						24a. Was autop perfor	sv prior	e autopsy findings available to completion of cause of 1?			
Vita	sicien: Th certificate rector, pag	o Be (25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Othe		eath (Check only o					
n of	ding Phys h. After this funeral dir	\vdash	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	1000	-0.111		lence 6 Other (S low injury occurred	Бреспу)			
Division	or Attendiation of the control of the color. A price of the form o	ertification:	2 Accident investigation 3 Suicide 6 Could not be		me, farm, str		res 2 □No	28f. Location (S	Street and Number or	r Rural Route Number.			
Ö	Itel or A irs after rel Direc led in by	Certi	4 Horricide	building, etc. (Specify	<i>'</i>)			City or Tow					
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certification of the funeral director; completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowning: On the basis of examinate and manner stated.	wledge, death tion and/or inv	occurred at the tim restigation, in my op	e, date and pla pinion, death oc	ce, and due to the c curred at the time, c	cause(s) and manner date and place, and a	r as stated. due to the cause(s)			
)	To t To t	Σ	29b. Signature and title of countries	MO		29c. License	1564		29d. Date signed (Mi	onth, Day, Year)			
1	0		30. Name and address of person who	completed cause of death (Item	23а) (Туре,	Print)	Time	RI	214/05	B			
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 8	completed cause of death (Item 2005 2005	ture	porte							

			For State Registrar	State of Ma	aryland / De _l	oartment e <i>rtificate</i>	t of He	ealth a <i>eath</i>	and Me		gien Reg. No		5	03749
			1. Decedent's Name (First, Middle, La	ast)						2. Date of De	ath			3. Time of Death
	Physici /Medic		MANUEL	SUM	WART	2				Pers	Da		Year	12:15 M
	Examin		4a. Facility Name (If not institution, gr				Town, or L					. County	of Death	
				HOTSLLY		- ' ' '	NDA	/	•	,	_		CPIN	rone
	Funeral Director		5. Social Security Number 6. 218-01-3213	Sex 7. Ag 1 M 2 ☐ F	e (In yrs. last birthda 85 Yrs.	y) If Under Months		Hours 2	Min.	8. Date of Bird 03/21/	th Ұ∙Ճ °	3	9. Birthp	place (State or Foreign htry) MD
			Usual Residence of Decedent		00 110					03/21/	1913	,		עויו
	ylanc		10a. State 10b. County		10c. City, Town or								1	0d. Inside City Limits
	Ba-fs	ctor	MD BALTIMO	RE	BALTIMOR	E							İ	1 ☐ Yes 2 🗖 No
	ith th or 28	Director	10e. Street and Number			10f. Zip						tizen of W	hat Coun	itry?
	s 23a		6501 SANZO ROAD A				209					S.A.		
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it e Medical Examinat must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 M Yes 2 1 M 1 Yes Give Year or Dates:		If Yes, special 1 Yes 2		Danic Orig Mexican Specify:	jin? (Spec , Puerto R	ofy Yes or No- lican, etc.)			White,	
5-0	72 ho	Completed	15. Decedent's E (Specify only highest gr		16a. Dec	edent's Usual	l Occupation	on ring most	of working		16b. H	and of Bus	siness/Inc	dustry
21	ithin ne.	npie	Elementary/Secondary (0-12)	College (1-4or 5	i+)	re kind of wor DO NOT us	e retired)	ring most	OI WOIKIN	9				
2	filed w Hygier ther th		11		SALE	SMAN						NS CL		NG
Maryland	should be find Mental Finarked of	To Be	17. Father's Name (First, Middle, Last	, 	SCH	WARTZ	- 1	8. Mother		(First, Middle,	Maider		, KAUF	MAN
	alth and 27 is m		19a. Informant's Name/Relationship TERESA SCHWARTZ /	,, .,						Route Numbe			itate, Zip	Code)
ore,	of Hearlitem		20a. Method of Disposition	7.0	20b. Place of Disp	position (Nam	e of		Da	te	20c. L	ocation - C	ity or To	wn, State
<u><u>Ë</u></u>	Page nent ant: ff ury or		1 🗖 Burial 2 □ Cremation 3 [`4 □ Dopation 5 □ Other (Speci		AGUTA'S' A	NG.	NSHE	2	/06/2	2005	BAL	TIMO	RE,	MD
Baltimore,	permit. Pages 'Department of the important: If ite any injury or ot once.		21. Signature of Funeral Service Uce	Juge		22. Name and 8900 RI	Address EJSTE	RSTO	WNOI RI			ŤLBR	OS _{MD}	JNC 21208
П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not e	nter the mode	of dying,	such as c	cardiac or	respiratory ar	rest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	ASPIRA	T/02	Ρ	NEI	umo	NIA				Onset and Death
Н	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):		^							
н		5	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	DYJ PH	A411	+							
	uted I	min	cause. Enter Underlying Cause (Disease or injury		RIOR C	FREE	31201	VAC	2481	M	EV.	ENT		
Ć	exection and ial-tra	Exa	that initiated events resulting in death) Last	0.	a consequence of):	20. 01.			COIC	7(10	0.			
68760,	icate be executed physician and s the burial-transit	dicai Examiner	(d										
		40	IF FEMALE:											
P.O. Box	es that the death certific igned by the attending p be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		□Ectopic pre	gnancy					23d. Date		•
о. П	the at	sici	1 Yes 2 No	4□Pregnant at 9□Unknown		Other (spe						Mont	h I	Day Year
	hat the set by detac	Phy	Part II. Other significant conditions	contributing to death by	it not resulting in the	Lindarhina ca	uco antos	in Bort I		23a Did ta	bassa	ion contrib	uto to the	e cause of death?
ds,	signe d be	d by		SIRUUI	- ^	LMONA			BASI	-				ably 4 □Unknown
COL	w require been sig should b	iete				(• • • •		- 10	0.440		·	1		
Re	he lar e has ige 2	Completed								24a. Was a autop: perfor	sy	pri	ere autop or to com ath?	sy findings available apletion of cause of
ta	ificate or, pa	e Co	25. Was case referred to medical					a Olean	-15	1 Yes	2 No			2□No ·
>	ysicia s cert direct	To B	examiner?	Hospital:	nt 2 ER/Outpatie	ent 3 DOA	Other			Check only of 5 ☐ Resid		€ □Othor	(Canait.	
Division of Vital Records,	g Ph ter thi		27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Time		c. Injury at			d. Describe h				/
jo	oteath. ctor: Afi y the fur	atio	1 Natural 5 ☐ Pending investigatio		Year) Injury	М	Work? 1 ☐ Yes	s 2 🗆 N	0					
<u>.</u> ≤	r Atte	Certification:	3 Suicide 6 Could not be determined		ry - At home, farm, s	treet, factory,	office		28	f. Location (S City or Town			or Rural	Route Number,
	urs aff rai Di		→									,		
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edicai	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	nysician: To the best of niner: On the basis of and manner state	examination and/or i	th occurred at nvestigation, i	t the time, in my opini	date and ion, death	place, and occurred	d due to the c at the time, d	ause(s)	and mann	ner as sta d due to	ited. the cause(s)
	o the	Med	29b. Signature and titly of contifier	and manner sta			License no					e signed (
			* Wal.	mlunt	TAD		-	539	O			BS		
	. 4	4	30. Name and address of person who	completed cause of de		, Print)		. ,						
	W .		A. MAHESHWA	RI, MD /	oath (Item 23a) (Type NORTHWT r's Signature	ST HO	TIPLL	AL	RAI	V DALL!	072	WN,	MD	
	Sta Registra		31. Date filed (Month, Day, Year) EER 0 8 2[105 Jacob	S Signature	perti								

			1 - For State Registrar	State of Maryland / Depa	artment of Health and Natificate of Death		ene .No.2005	03750
	Physic /Medi		Decedent's Name (First, Middle, Las John T	Toolan		2. Date of Death Month	Day Year	3. Time of Death
	Examii			MEDICAL CUITER	4b. City, Town, or Location of Death	Cii		imore
	Funeral Director		5. Social Security Number 6. Social Security Number 11 3 14 -03 -4245 11 Usual Residence of Decedent	X M 2 F 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	gai) Cour	place (State or Foreign http) RYLANO
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural, or Itams 23a or 28e-f show any injury or other treumatic event, Ita Malical Examinat must be notified at once.	ctor	10a. State 10b. County MD BALT N	10c. City, Town or Lo	1		1	0d. Inside City Limits 1 ☐ Yes 2 No
		rai Director	10e. Street and Number 300 INTERNA	rional Circle.	101. Zp Code		. Citizen of What Cour USA	ntry?
936		by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 DAYes 2 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 220 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	ean Indian, etc.
21215-0036		Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	te completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ting 16	b. Kind of Business/Inc	ustry
and 21		Be	17. Father's Name (First, Middle, Last)	700/00	18. Mother's Nam	e (First, Middle, Mai	arton+ iden Sumame)	Coton
Maryland		To	19a Informant's Name/Relationship (T	ypo, Print) 19b. Mailir es - Daug 12411	ng Address (Street and Number or Run	al Route Number, C	ity or Town, State, Zip	Code)
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify,	Removal from State 20b. Place of Dispo	instition (Name of matory or other place)		c. Location - City or To	
Balt			21. Signature of Funeral Service Udens	Vallotary EV		TIMORE,	MD 210 WHARFOR	134.
	Physician / Medical Examiner transit the private transit trans		23a. Part1. Enter the disease, of comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do not ent ne cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
		-G		Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		MONTHS		
		Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c				
68760,	phy the	Medicai	IF FEMALE:	d				
.O. Box	at the death certifi by the attending p tached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		23d. Date of deliver Month	ry Day Year
Records, P	The law requires that the tee has been signed by the page 2 should be detache	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						e cause of death?
al Reco		Completed				24a. Was an autopsy performed	prior to con death?	osy findings available opletion of cause of
of Vital	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 \(\sum \text{Yes} \) 2 \(\text{No} \) No	Hospital: 1 Inpatient 2 ER/Outpatien	Othor	n (Check only one) me 5 ☐ Residence	e 6 □Other (Specify)
Division o	ding h. After fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28d. Describe how injury occurred			
DİVİ	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo		4 Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	To the Hos	fedical		sicien: To the best of my knowledge, death ner: On the basis of examination and/or inv and manner stated.		and due to the cause ed at the time, date	(s) and manner as sta and place, and due to	ated. the cause(s)
) ^	To Twith	×	A. J. Helay M. D. February					2005
12	The same		30. Name and address of person who co	ompleted cause of death (Item 23a) (Type, I	Print)	11:45	in Ersac	
	Sta Registr	_	31. Date filed (Month, Day, Year) FEB 0 8 2	32. Record rates Signature	Snack i			

			For State	State of Maryland		irtment of H			2005	03751	
			Registrar 1. Decedent's Name (First, Middle, Last)			tinoato oi		Reg. A 2. Date of Death	ю. • • •	3. Time of Death	
	Physicia		0 = 11 = 00 1	1-150				Month D	ay Year	11 0 M. M	
	/Medic		4a. Facility Name (If not institution, give s	treet and number)		4b. City. Town. o	or Location of Death	FEBRUAR	c. County of Death	11.	
	Examin	er				Par		1	·	0.55	
			5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ast birthday)	If Under 1 Year	If Under 24 Hrs.	B. Date of Birth (Month, Day, Yea	3AL 1000	olace (State or Foreign	
	Funeral Director	1		M 2□F NY	Yrs.	Months Days	Hours Min.	(Month, Day, Yea		TUCKY	
			Usual Residence of Decedent					3	1 10.0		
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation			1	Od. Inside City Limits	
	Mar a-fal	to	MARYLAND BATTER	Shor	HAR	Kville				1 ☐ Yes 2X No	
	h the	Director	10e. Street and Number			10f. Zip Code		10g. (Citizen of What Cour	ntry?	
	h wit	ä	3110 EALIFORD	IN AVE		21/2	73 <i>H</i>		V.S.A.		
	hours after death with the Maryland tural; or Itams 23a or 28a-f ahow at Everyllar must be prefitted at	Funerai		12. Was Decedent Ever in U.S Armed Forces?	S. 13.\	Was Decedent of H	Hispanic Origin? (Specan, Mexican, Puerto R	ify Yes or No-	14. Race - Americ Black, White,		
9	after or its	E.	1 ☐ Never Married ZX Married	1 X Yes 2 ☐ No If Yes, Give		l □ Yes 21≦ No	Specify:	, (10.)		010.	
ဗ္ဗ	rai',	d by	3 Widowed 4 Divorced	Year or Dates:			opoony.		Specify: W	HITE	
21215-0036	72	Completed	15. Decedent's Edu (Specify only highest grade		(Give	lent's Usual Occup kind of work done	during most of workin	g 16b.	Kind of Business/In	dustry	
21	within ene. than "	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire				_	
	filed will Hygiel other ti		13785		7271-	51.11.171	100-00kg		ESTAURE	101	
<u>n</u>	be d la	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(FIRST, MIGGIE, MAIG	en Sumame)		
yla	should be and Menta marked umatic e	၉	1507 1072y	11-11-11			3. Llix	HOSK	201	0.000	
Maryland	2 sho		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	g Address (Street	and Number or Rural	Route Number, City	or Town, State, Zip	1981 (Code) 31334	
	s t and 2 should f Health and Men itam 27 ia marke other traumatic		ratol O Anost	205 8	3110	Sition (Name of	JUIT HA	- I BUSKO	Location - City or To	RYLAND	
altimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State . CE	əmetery, crer	natory or other pla			Location - City or 10	own, State	
Ë	men tant: jury		'4 □ Donation 5 □ Other (Specify)	Holl		SARY	200		Throne L	1 laryland	
Ball	permit. Pag Department Important: I any injury o		21. Sign turn of Funeral Certific License	90		Name and Addre	ess of Facility	siant.	(2) m	48.B16	
_	⊈O ≅ a o	Ш	They have	A			RFORD ROOM	O HARK	Al I shir	SYLAND	
и	Fnysician		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death re cause on each line.	n. Do not ent	er mode of dyl	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death	
		Immediate Cause (Final disease or condition Net as at the Control Onset								700025	
	/Medical		resulting in death)	Due to (or as a consequ	uence of):					. (
E.	cate be executed with physician and physician and street the burial-transit	.		o							
		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Oue to (or as a consequence or):							
		cam	that initiated events resulting in death) Last	Due to for each consequ	as a consequence of):						
8760,	oe ex cian ourial	E E		Due to (or as a consequ	derice orj.						
87	cate t	dicai		d							
9	ding F	Me.	IF FEMALE:	20 If you outcome of orogen	nov.		-				
Вох	eath certifii attending I I for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1						23d. Date of delivery Month Day Year		
0	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown	eath 5	Other (specify) _					
Ф.	that the de ned by the a detached t		Part II. Other significant conditions con	ntributing to death but not resu	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?	
Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	l by		,	3	, , , , , , , , , , , , ,		1 🗆 Yes	2 ANo 3 Prot	pably 4 □Unknown	
0		Completed								Carlana	
ec	elaw has b	n Jdu						24a. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of	
E		Ö						1 ☐ Yes 2 🔀		2□ No	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		04	26. Place of Death		-		
of	d is	2	1 162 5 5 140	1 □ Inpatient 2 □	ER/Outpatier	IL JUDON			6 ☐ Other (Special	(y)	
	ftel ftel	ion	27. Manner of Death 1 Shatural 5 Pending (Month, Day Year) 2 Accident 5 Could not be determined 28e. Place of Injury At home, farm, street, factory, office 28d. Described 28d. Described Work? 1 Yes 2 No 28d. Described Work? 1 Yes 2 No 28d. Described No. 1 Yes 2 No 28d. Described No. 1 Yes 2 No 28d. Described No. 1 Yes 2 No. 28d. Described No. 1 Yes 2 No. 28d. Described No. 1 Yes 2 No. 28d. Described No. 28d.						28d. Describe how injury occurred		
Sic	l or Attanding after death. Diractor; Afte	icat							n (Street and Number or Rural Route Number,		
Division	or At after o Diraci in by	Certification:	4 Homicide determined	building, etc. (Specify	y)	eet, lactory, office	-	City or Town, St.		ar rioute realibor,	
	pital ours a arai		29a. Certifier TS Certifying Phy	sician: To the best of my kno	wladna daat	h occurred at the t	ime date and place a	nd due to the cause	(s) and manner as s	tated	
	To the Hospital or Attandi within 24 hours after death. To the Funaral Diractor, A completely filled in by the fu	Medical	(Check only 2 Medical Exami	ner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my	opinion, death occurre	d at the time, date a	and place, and due t	o the cause(s)	
	o the	Me	29b. Signature and title of certifier			29c. Licen	se number	29d. I	Date signed (Month,	Day, Year)	
	H3H8	X	> Close Con Co	(Kortaal) 1105		20	5546		0 0. 15	7 00-0	
•	(1)		30. Name and address of person who or	ompleted cause of death (Item	23a) (Tumo	Printh >		150	5 RUARY T	1 2000	
	10		30. Name and address of person who co	ttime SH		och Ro	ven Bliz	O Rob	to word	US 71730	
	Q+	ate	31. Date filed (Month, Day, Year)	32. Regis ar's Signa	ture	1		1,000	(Cross		
	Regist		FFR 0.8	2005 Herewa	K	Spell					

			For State Registrar	State of	Maryland / D	epartment of l			giene200	5 03752	
			Decedent's Name (First, Middle					2. Date of De	ath	3. Time of Death	
	Physici /Medic		LLOYD	P TUI	RNGR			Februa		7:00a. M	
	Examin		4a. Facility Name (If not institution,	give street and num	ber)	4b. City, Town,	or Location of Dea		4c. County of [*	
			Catonsville Com			Catons			Baltim		
	Funeral		5. Social Security Number	6. Sex 7 1 X M 2 □ F	'. Age (In yrs. last birth	day) If Under 1 Year Months Days		. (Month, Da	th y, Year) 9.	Birthplace (State or Foreign Country)	
	Director		215-10-1472 Usual Residence of Decedent		87	13.		Aug.13	, 1917 M	[aryland	
	yland		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits	
	a-fsl	ctor	Maryland Balti	more	Catons	sville				1 ☐ Yes 2X No	
	be filed within 72 hours after death with the Maryland ald Hyglane. Ald Hyglane. And chher than "natural", or items 23a or 28a-f show event, the Madical Exertifier must be notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	it Country?	
			1 Ginford Place			21228	3		USA		
	er de Items	Funera	11. Marital Status	Armed Fore	dent Ever in U.S.	 Was Decedent of If Yes, specify Cub 	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No rto Rican, etc.)		American Indian, White, etc.	
36	I's aft	by F	1 ☐ Never Married 2X Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:		Specify:	White	
Ö	2 hou		15. Decedent	s Education	16a. E	Decedent's Usual Occu	pation		16b. Kind of Busin	ess/Industry	
215	thin 7 9.	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-		Give kind of work done life. DO NOT use retire	e during most of wo ed)	orking		,	
2	ed wil	Con		5+		orney			Corp Ins.	Industry	
pu	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, I.e.M.	Be	17. Father's Name (First, Middle, I	ast)					Maiden Surname)		
3	d Mer narke	J.	Joshua Turner	in Const. China				ine E. P			
Mai	d 2 st th and 7 Is r traun		19a. Informant's Name/Relationsh John Turner	ip (<i>Type, Print)</i>		Mailing Address <i>(Stree</i> 510 Old Mar					
ē,	ges 1 and 2 should it of Health and Men If item 27 is marke or other traumatic		20a. Method of Disposition		20b. Place of I	Disposition (Name of	į.	Date	20c. Location - City		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra 20029.		1 ☐ Burial 2 🏝 Cremation 1 ☐ Donation 5 ☐ Other (Sc		tate	, crematory`or other pla	' 1	2005			
			21. Signature of Funeral Service L		ballo.v	Vash.Cremat	ess of Facility		Laurel, M		
ä			Hater &	delet		736 Edmo	g Ashton ondson Av	Schwab F enue: Ca	uneral Ho	me, Inc. , MD 21228	
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that ca	used the death. Do no	ot enter the mode of dy	ing, such as cardia	c or respiratory ar	rrest,	Approximate Interval Between	
	Pnysician /Medical Examiner	1	Immediate Cause (Final disease or condition Herry Cardia Variable Sisters Onset and Dea								
			resulting in death)	Due to (c	r as a consequence of						
	Zammer	<u>_</u>	Sequentially list conditions	b. Due to (c	177	~				Ys.	
	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or righty)								
Ć,	execu n and ial-tra	Examine	that initiated events resulting in death) Last	c Due to (o	or as a consequence of):					
8760,	the death certificate be executed y the attending physician and iched for use as the burial-transit	dicai		d							
9	certifica nding ph use as th	Jedi	IE ECMAN E.								
Вох	attending for use as	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		ome of pregnancy th 2 Tetal death	3 □Ectopic pregnanc	ev		23d. Date of		
	the at	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregna 9☐ Unknov	nt at time of death wn	5 Other (specify)	•		Month	Day Year	
P.0	that the de ed by the detached	Certification: To Be Completed by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e Did to	23e. Did tobacco use contribute to the cause of de		
Records,	89 Pg 99			518	CVA	aa, 1g caacc g.	TOTAL CONTRACTOR			Probably 4 Junknown	
COL	w requir been si should							24a. Was	an 24h Were	e autopsy findings available	
Re	The tav							autop perfo	prior deat	to completion of cause of h?	
Vital			25. Was case referred to medical				26 Place of De	1 ☐ Yes eath Check on o	2 1 1 1	Yes 2□ No	
f V	\$ S = B		examiner? 1 Tes 2 No	Hospital: 1 ☐ In	patient 2 ER/Outp	patient 3 DOA Ot			dence 6 🗀 Other (5	Specify)	
n of	ng Ph fter th ineral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Month)	Injury 28b. Tir , Day Year) Inj	me of 28c. Inju			now injury occurred		
Division	Attending r death. ector: After y the fune		2 Accident investigation 3 Suicide 6 Could not be								
ΣĬ	or At offer of Direct in by	irtifi	4 Homicide determi	ned 286. Flace (of Injury · At home, farr g, etc. <i>(Specify)</i>	n, street, factory, office		28f. Location (S City or Tov		r Rural Route Number,	
J	ours seral I		29a. Certifier 1 Certifying	Physician: To the l	pest of my knowledge,	death occurred at the t	ime data and also	e and due to the	called(s) and	r as stated	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical 6 one)	xeminer: On the bas	sis of examination and/ er stated.	or investigation, in my	opinion, death occ	urred at the time,	date and place, and	due to the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier	1	After al	29c. Licen	se number		29d. Date signed (M	fonth, Day, Year)	
)	10		> Kula-	pro.	NY	1 1	3694	2	February	4.2005	
	rb		30. Name and address of person y	no completed cause	of death (Item 23a) (T	ype, Print)	- 1	70	. 0 10 0	. ,	
			15. IUKHKHI	7, MD /	509, Fred	exict Rd.	Catenda	ice, M	5 4168		
	Sta Registr		31. Date filed (Month, Day, Year)	8 2005 ^{32. Re}	guerrar's Signature	Books				r as stated. due to the cause(s) fonth, Day, Year) 4, 2005	
						- 25					

Kenneth J. Watts Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-00916 State of Maryland / Department of Health and Mental Hygiene DOS State
Registrar AMEND ITEM #2 PER ME C 840 2,08,05 JH
Decadent's Name (First, Middle, Last) Reg. No 2. Date of Death 04 3. Time of Death **Physician** Kenneth John Watts February 5, 2005 1608 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Greater Baltimore Medical Center Towson 8. Date of Birth Month, Day, SEP 2, 6. Sex 14 M 2 F If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 218-64-3907 49 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I're Medical Exa of et marke notified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1X Yes 2 □ No Maryland N/A Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3851 Roland Avenue 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bfack, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1971-77 1 ☐ Yes 2 No Specify: White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1.2 College (1-4or 5+) General Manager Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kenneth John Watts Mildred Zeller 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet M. Morningstar/Wife 3851 Roland Avenue Baltimore, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Metro Crematory, Inc. 2/7/05 Baltimore, MD 21. Signature of Funeral Service Licensee Cremation Society of MD, Inc. 299 Frederick Road Baltimore, Edward A. Gregor del Gregorchik Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) Athenselente **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the t IF FEMALE: use: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No þ Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1,⊠Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 🗆 No To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 XYes 2 No 1 Inpatient 2 ER/Outpatient 3 XDOA this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After thi
completely tilled in by the funeral of 28d. Describe how injury occurred 27 Manner of Death 28b Time of 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending 1 Yes 2 No investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little OCME February 5, 2005 eted cause of death (Item 23a) (Type, Print) 30. Name and address of person who 111 Penn Street Baltimore MD 21201 egistrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3,2005 **Physician** Year Louise V . Williams Feb 6 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 815 Winters Lane (Home) Catonsville N/AIf Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5-7-1932 6. Sex **Funeral** 1□M 2XF Yrs. Director 217-28-5512 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other freumatic event, the Mudical Example must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1X Yes 2 ☐ No Director Md. N/A Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 815 Winters Lane 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Yes 2 XNo Specify þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Harry Williams Isabelle Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9210 Oswald Way, Apt1D, Baltimore, Md. 21237 Williams Rodney 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial X☐ Cremation 3 ☐ Removal from State Metro Crematory 2/7/05 * 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, Md. 22. Name and Address of Facility
Estep Brothers Funeral Ser P.A.
1300 Eutaw Place, Baltimore, Md. 21217 21. Signature of Funeral Service Licensee Lloyd M. Estep

Estep Brothers Funeral

1300 Eutaw Place, Balti

23a. Part. Enter in disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DiCated (a) di Physician /Medical Due to (or as a consequence Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed 1574 and Due to (or as a co Division of Vital Records, P.O. Box 68760 ed by the attending physicien detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 Types 2 WNo Day Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ bnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an certificate has page 2 1 ☐ Yes 2 1 → Mo director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 10 Certification: To this 27. Manner of Death 1 ☑Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After or Attending 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation ofter death Director: / the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hin 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

within 24 ho To the Fune completely fi

DHMH 17 Rev 1/2001

2

State Registrar (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2005

ame and address of person who completed cause of death (Item 23a) (Type, Print)

MD

1009

32. Register's Signature

Frederick

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Rd.

36942

BACTIMORE, NO 2/228

29c. License number

MD 32576

29d. Date signed (Month, Day, Year)

January 19, 2005

Physician /Medical **Examiner** executed P.O. Box 68760 the death certificate be Division of Vital Records, or Attending Physician:

and -trans the attending physician a use as signed by peq peen has this certificate After To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A in by t

Physician

/Medical

Examiner

Funeral

Director

ir than "natural", or Items 23e or 28a-f show

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n, any injury or other traumatic event, It a Media once.

Funeral Director

Completed by

Be

2

Examiner

Physician/Medical

þ

Completed

Be

٩

Certification:

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

5

DHMH 17 Rev 1/200

31. Date filed (Mooth Day, Year) FEB 0 8 2005

ati alla Colen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



			1 - For State Registrar		f Maryland		artmen rtificate			and Mental H	ygiene Reg. No		03756
ı	Physici	an	1. Decedent's Name (First, Middle FOP		Josef	ЭН	WA	GU	er	2. Date of E	Day		3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution	n, give street and nur			4b. City,	Town, or	Location of	Februa of Death		, 2005 County of Death	11:00 P ^M
		٠	5717 Ivy Way					odbi		0.11		Carrol	
П	Funeral Director		5. Social Security Number 215-07-2460	6. Sex 1 XM 2 ☐ F	7. Age (In yrs. Ia 85	ist birthday) Yrs.	If Under Months	Days	If Under Hours		av. Year)	9. Birth Con Mar	nplace (State or Foreign untry) Cyland
	ס		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	L L			7100)) 11ct1	
	Maryla f sho	ō	,	rroll	Too. City,		oodbir	20					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th the or 28e	Directo	10e. Street and Number	22011		VVC	10f. Zip				10g. Cit	izen of What Co	
	s 23e	ral	5717 Ivy Way	10.111					797			USA	
(0	ifter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	Armed For	2 🗌 No					gin? (Specify Yes or N , Puerto Rican, etc.)	10-	14. Race - Amer Black, White	
003	72 hours after death with the Maryland neturel; or Items 23e or 28e-1 show disal Exat; it wermust be multifud at	d by	3 XWidowed 4 ☐ Divorced		ates: 1942-	45	1 ☐ Yes 2	Λ	Specify:			Specify: W	hite
21215-0036	C 2	plete	(Specify only highe	t's Education st grade completed)		16a. Deced (Give lite. I	dent's Usua kind of wor DO NOT us	l Occupa k done d e retired,	ition luring mosi)	t of working	16b. Ki	ind of Business/I	ndustry
	filed within I Hygiene. other than "rent, If a Mer	Completed	Elementary/Secondary (0-12)	College (1	-40r 5+)	Di	spate	cher				Dil Comp	any
Maryland		Be	17. Father's Name (First, Middle,							r's Name (First, Midd		Sumame)	
aryl	2 should be and Mental Is marked eumatic ev	2	Owen Frances 19a. Informant's Name/Relations			19b. Mailir	ng Address	(Street a		rian Oakle or or Rural Route Num		r Town, State, Z	ip Code)
Ž,	and 2 ealth a n 27 ls	1	Sharon Krauss/	Daughter		5717	7 Ivy	Way	Wood	bine, MD 2			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked eny injury or other treumatic et <u>once.</u>		20a. Method of Disposition 1 ☐ Burial 2 X Cremation		State	ace of Dispo metery, crer				Date		ocation - City or T	
Ħ	artmer ortent injury		*4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service	Licensee //	Met					2/5/05	_Bal	timore,	MD
ä	Depar Impo eny ir		Edward A.	regorchik			remat 299 Fr	cion ceder	Soci	ety of MD, Road Balti	Inc. more.	MD 212	28
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that conly one cause on e	ach line.	Do not ent	er the mode	of dying	, such as				Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to	or as a conseque	ence of):							-
	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	or as a conseque	ence of):							
	death certiticate be executed e attending physician and id tor use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conseque	ence of):							
8760,	e be e /sician e buria			d.									
9	ntiticat ing phy e as th	Medi	IF FEMALE:										
Вох	eath certitic attending p	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	come of pregnan inth 2 Petal of ant at time of dea	death 3	Ectopic pre				2	23d. Date of delive Month	rery Day Year
P.O.	that the de ed by the detached	hyslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno		201 5	J Other (spe						
Vital Records, F		by	Part II. Other significant condition		eath but not result			iuse give	n in Part I.	23e. Did	,*		the cause of death? bably 4 Unknown
eco	The law requires ite has been sign age 2 should be	ompleted	_ Acute RE	VAI PAIL	ure					24a. Wa	psv	24b. Were aut	opsy findings available ompletion of cause of
al B		O								per 1 ☐ Yes	ormed? 2 X No	death?	2 □ No
Zit	Physicien: this certitional director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	npatient 2□E	R/Outpatien	t 3 DO	A Othe		of Death (Check only rsing Home 5 X Res		3 □Other (Speci	fu)
n of	ding Phy h. Atter thi funeral (on: T	27. Manner of Death 1 Natural 5 Pendin	28a. Date		28b. Time of Injury		3c. Injury Work	at	28d. Describe			•57
Division	Attending r death. sctor: Atter	ertification:	Accident investig	gation not be 200 Bloom	of Injury - At hon	ne farm str	M eet factory		es 2 □ h		/Street and	d Number or Rur	al Route Number,
DΪ	s effer of Dire	Certil	4 Homicide determ	buildi	ng, etc. (Specify)	10, 14111, 311	oot, ractory,	omoo		City or To	wn, State))	ar ricote rember,
	To the Hospitel or Attending Ph within 24 hours efter death. To the Funerel Director: After th completely tilled in by the funeral	edical (29a. Certifier Certifyin (Check only one) Certifyin	g Physicien: To the Exeminer: On the band man	asis of examination	ledge, death on and/or inv	occurred a restigation,	at the time in my op	e, date and inion, deat	d place, and due to the h occurred at the time	cause(s) , date and	and manner as s place, and due t	stated. to the cause(s)
	To the To the Comp	ğ	29b. Signature and title of certifie	1.			29c.	License			3	e signed (Month,	Day, Year)
	*		70 Name and address of parson		a of death "	اکل	Beier	とう	ا الحال	,0	215	12005	200
	10		30. Name and address of person		C ZZ	C1 5	1000	a A	الاسان	e west	mins	iter, m	ARY LAND
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0	8 2005 32. R	ecotrar's Signatu		local?	3					

DHMH 17 Rev 1/2001

		•	1- For State of Maryland / Dep	partment of Health and Mental Hygertificate of Death	gien 2005 03757									
	Physicia	20	Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Day Year									
	/Medic	_	Howard Charles Wenderoth	Februar	-									
	Examin	er	4a. Facility Name (If not institution, give street and number) 610 FLintlock Drive	4b. City, Town, or Location of Death Bel Air	4c. County of Death Harford									
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) If Under 1 Year If Under 24 Hrs. 8. Date of Birt										
	Funeral Director		216-24-6736 17 M 2 F 74 Yrs.	Months Days Hours Min. (Month, Day May 18	1930 Maryland									
	pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	ogation	10d. Inside City Limits									
	faryla ehov	5		Bel Air	1 ☐ Yes 2 ☑ No									
	289-1	Director	Maryland Harford 10e. Street and Number		10g. Citizen of What Country?									
	3a or		610 Flintlock Drive	21015	U.S.A.									
	death	Funeral		. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.									
98	or Ite	by Fu	1 ☐ Never Married 2 ☐ Married 1 🕅 Yes 2 ☐ No	1 ☐ Yes 2 ☒ No Specify:	Specify: White									
5-0036	72 hours after death with the Maryland 'natural', or Items 23s or 28s-f ehow disel Examinat must be notified at	q pe	3 ♥ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b. Kind of Business/Industry									
15	n na	Completed	(Specify only highest grade completed) (Gir Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)	Liquor Wholesale									
2121	d within giene.	mo:		uter Programmer	House									
pu	be file	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,										
yla	12 should be filled within h and Mental Hygiene. 7 is marked other than *	ဥ	Howard B. Wenderoth	Margaret Wah Iling Address (Street and Number or Rural Route Numbe										
Maryland	d 2 sh th and 7 is n treun			Flintlock Drive, Bel Air										
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28e-f ehow other treumatic event, the Medical Examinar manual te notified at		20a Method of Disposition 20b. Place of Dis	position (Name of Date lematory or other place)	20c. Location - City or Town, State									
m _o m	Pages nent of h ent: If ite ury or o		1 ABurial 2 Cremation 3 Removal from State		Baltimore, Maryland									
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 any Injury or other tr once.			22. Name and Address of Facility Schimunek 9705 Belair Rd., Baltimor	Funeral Homes									
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		•									
E	Pnysician		Immediate Cause (Final disease or condition Adeno carcinoma Leff Lyng Onset and Death											
	/Medical Examiner		resulting in death) Due to (or as a consequence of):		2 months.									
	LAGIIIIIEI	<u>.</u>	Sequentially list conditions b. Brain and b. Due to (or as a consequence of):	d Bone Metastasis	& Months.									
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury											
Ć.	be executed acien and burial-transit	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of):											
8760,	ate be executed hysicien and the burial-transit	dlcal	d		was the									
9	artifica ing ph e as th	Med	IF FEMALE:											
Вох	leath certifica attending ph I for use as th	ian/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year									
o	that the death ed by the atte detached for	iysic	1 Yes 2 No 9 Unknown	Other (specify)										
Ф	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did to	bacco use contribute to the cause of death?									
rds	w require: been sig should b	ed b	Hypertensian	1 🗆 ١	es 2 No 3 Probably 4 Unknown									
900	e law requ has been ge 2 shoulk	plet	Hypertensian Hyper Cholesterolemia	24a. Was autop	sy prior to completion of cause of									
H.		Com		perfo 1 ☐ Yes	med? death? 2 No 1 Yes 2 No									
/ita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only o										
of	Physician: this cartific ral director,	2	1 ☐ Yes 2 1 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat 27. Manner of Death 28a. Date of Injury 28b. Time		ence 6 Other (Specify) ow injury occurred									
O	ding h. After fune	tlon	27. Manner of Death 1 Matural 5 Pending 2 Accident Accident Accident State of Injury (Month, Day Year) 28a. Date of Injury (Month, Day Year)		,,									
Division of Vital Records,	Atten r deal ector by the	ifica	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. Location (S City or Tow	Street and Number or Rural Route Number,									
Ö	tel or s afte el Din	Certification:	a Información	Ony or You	n, state)									
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de control on the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due to the investigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)									
	To the To the Comp	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)									
	,		1900	V0010427	Feb-7-2005									
	10+1		30. Name and address of person who completed cause of death (Item 23a) (Typ 13. Parekh M.D. 1908 Hart	e, Print) Road, Fallston, I	49.21047									
	Sta Registi		31. Date filed (Month, Day, Year) FEB 0 8 2005	di										

			1 - For State Registrar	State of M	larylan	d / Depa <i>Cei</i>	artment of H	ealth a	ınd Men		giene	5 (03758
١	Physicia	an	1. Decedent's Name (First, Middle, Las Maria Magdalena Wi							Date of Dea Month	Day	Year	3. Time of Death 1:00P M
	/Medic Examin	al	4a. Facility Name (If not institution, give)		4b. City, Town, or	Location of		ebrua	-	ty of Death	
	LAdiiiii	Ci	4713 Macon Road				Rockvil				Mont	gomer	У
	Funeral Director		214 30 0313	7. A	ge (In yrs. 78	last birthday) Yrs.	ff Under 1 Year Months Days	If Under 2 Hours	Min. Ma	Date of Birt (Month, Da Ly 12,	y, Year) 1926	_ Cour	place (State or Foreign ntry) many
	show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome	ery	1	y, Town or Lo						1	10d. Inside City Limits 1 ☐ Yes 2X No
	the h	rect	10e. Street and Number				10f. Zip Code				10g. Citizen o	f What Cou	ntry?
	n with	i Di	4713 Macon Road				2085	52			United	l Stat	es
20	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or Items 23e or 28e-f show that the Medical Examble routile 1 at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	? No		Was Decedent of H if Yes, specify Cuba 1 ☐ Yes 20 No	ispanic Orig in, Mexican Specify:	gin? (Specify , Puerto Rica	Yes or No- an, etc.)	ВІ	ace - Americ lack, White, cify: Whi	etc.
Maryland ZIZIS-0036	thin 72 hou e. en "neture Wedical E	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or	5+)	(Give	dent's Usuaf Occupa kind of work done of DO NOT use retired	during most	of working		16b. Kind of	Business/In	dustry
7	ygien ygien rer th	Con	_	2		Labor	atory Sur				Hospit		
/iand	utd be fil Mental H Irked otl	To Be	17. Father's Name (First, Middle, Last) Adolph Stugg						Melt:				
re, mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or Items 23e or 28a-1 show any injury or other treumatic event, the Madical Examinat must be notified at ance.		19a. Informant's Name/Relationship (7 Shirley A. Kingsle 20a. Method of Disposition			25113	Woodfiel with the state of the	d Sch	1001 Ro	oad, (_	sburg	, MD 20882
Ē	Pages ent of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		Nat	Arling	ton Cemetery	1 +	ebrua:	ry 5	Arlingt	on, V	irginia
Baitimore,	permit. Departm Importe any inju		21. Signature of Funeral Service Licen	1	0689	22	. Name and Addres	ss of Facility	Robert	t A. I	Pumphre	v Fun	eral Home/ nsin Ave.,
	Pnysician /Medical		23a. Part 1 Erker/he bisease, or compand to hear failure. List only of firmediate Cause (Final disease or condition resulting in death)	one cause on each	etic	h. Do not ent and Hy	er the mode of dyin	g, such as	cardiac or re	spiratory ar	rrest,		Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and e attending physician and for use as the burial-transit	dicai Examiner	Satuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a: Due to (or a: d.	s a conseq	uence of):							
O. Box 6	that the death certificated by the attending placed by the action use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcom 1□Live birth 4□Pregnant a 9□Unknown	2 Feta	I death 3	Ectopic pregnancy Other (specify)	,				Date of deliver	ery Day Year
s, T	200	b	Part II. Other significant conditions of Type 2 Diabetes	ontributing to death	but not res	ulting in the u	nderlying cause giv	en in Part I.			obacco use co Yes 2🎞 No		the cause of death?
Record	The ate h page	Completed						-	_		an 24b osy ormed? 2X No	prior to co death?	opsy findings available impletion of cause of
Vita	icien: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Oth		of Death (C				
ö	Jing After funer	tion: To	1X Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D		28b. Time o Injury	f 28c. Injur	4 🗀 140	28d.		dence 6 🗆 C how injury occ		fy)
Division	el or Attending s after death. Il Director: After id in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Ir	n j ury - At ho etc. <i>(Specif</i>	ome, farm, str fy)	reet, factory, office	1,18	28f.	Location (S City or Tox		mber or Run	al Route Number,
	To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by	edicai (ysician: To the bes niner: On the basis and manners	of examina								
	To the within 2 To the complet	Me	29b. Signature and title of certifier	5			29c. Licens				29d. Date sign		
			Jul agr	1 Cly	u		D0.	5120			Februar	ry 3,	ZUU5
1	33		30. Name and address of person who Michael Emmer, M.	D. 6316 D	emocr	сасу Во	oulevard,	Beth	esda,	Mary1	and 208	817–16	564
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Redis	strar's Signa	di di	porte						

			1 01	partment of Health and Mertificate of Death		211115 03750
			Hegistrar 1. Decedent's Name (First, Middle, Last)	nuncate of Beath	Reg. 2. Date of Death	3. Time of Death
	Physici		Henry Dent Willis		Feb 4,	2005 Year 4:25 A ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	LXdiffill	ÇI	403 Piney Run Ct.	Sykesville		Carrol1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Director		223-42-0949 ¹ ⊠M ² □F 73 Yrs.	Months Days Hours Min.	June 5,	1931 Virginia
	pu >		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or			
	sho	'n				10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	the M	ect	Maryland Carroll Sykesv:	ille 10f. Zip Code	100	
	a or	Funeral Director				Citizen of What Country?
	eath	era	403 Piney Run Ct. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S.	21784 . Was Decedent of Hispanic Origin? (Sp		ted States 14. Race - American Indian,
.	r Item	표	1 Never Married 2 Married Amed Forces? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
93	al', o	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1948 — Year or Dates: 1950	1 ☐ Yes 2 ☑ No Specify:		Specify: White
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28e-f show Jical Examiliar must be multified at	Completed	15. Decedent's Education 16a, Dec	edent's Usual Occupation	ing 16b	. Kind of Business/Industry
2	ithin Ben	nple	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	ang .	
	led w lygier her th			ims Adjuster		nsurance
Ē	be fil htal H hd ott	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	den Sumame)
3	toutd I Mer narke	2	Henry Leslie Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	Jovotte		
Maryland	d 2 sk th and 7 Is r treur			ling Address (Street and Number or Rura		
-	1 and Heal tem 2			Piney Run Ct. Syke position (Name of permatory or other place)		. Location - City or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumetic avant, the Modical Exercitival restricts to other treumetic avant, the Modical Exercitival restricts to other treumetic avant, the Modical Exercitival restricts to other treumetic avant, the Modical Exercitival restricts to other treumetic avant, the Modical Exercitival restricts to other treumetic avant, the Modical Exercitival restricts to other treumetic avant, the Modical Exercitival restricts to other treumetic avant, the Modical Exercitival restricts to other treumetic avant, the Modical Exercitival restricts to other treumetic avant.		X Buriar 2 Cremation 3 Linemoval from State			
Ė	artme artme orten injur	i	21. Signature of Euneral Senico I censee	View Cem. 2/8/2 22. Name and Address of Facility		nett, Maryland
Ba	Depa Impo any ir		William Bi	ırrier-Queen Funera		
			23a. Part1. Enter the disease, or complications that caused the death. Do not e	nter the mode of dying, such as cardiac	Kd. Winti or respiratory arrest,	eld, MD 21/84 Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Chronic obs	tructive pulmon	as ha	Interval Between Onset and Death .
	/Medical		resulting in death) a	Tru office parmore	11 y 1130	15 gear 2
	Examiner		Sequentially list conditions b.			
G	р 1 5	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
X	ecute and trans	Examiner	that initiated events c.			
8760,	cate be executed ohysician and the burial-transit		Due to (or as a consequence of):			
87	physics the l	edical	d			
9 X	eath certific attending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	death atter	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	☐Ectopic pregnancy ☐ Other (specify)		Month Day Year
P.O.	that the de ed by the detached	hysi	9 Unknown			
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?
rd	w require been sig should b	edk	rulmonory rodule		1 Tes	2 No 3 Probably 4 Unknown
Vital Records,	law requ as been 2 should	Completed by			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Ä		mo:			performed	death?
ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?		h (Check only one)	
of \	Physician: this certifica al director,	2	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati			
n c	ding P. h. After funera	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe how in	njury occurred
isic	uttand death ctor: / y the f	Icat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	28f Location (Street	and Number or Rural Route Number,
Division	after after Dirac	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	City or Town, St	ate)
_	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 15 Certifying Physician: To the best of my knowledge, de-	ith occurred at the time, date and place.	and due to the cause	e(s) and manner as stated.
	na Ho	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurr	red at the time, date a	and place, and due to the cause(s)
		Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
)	IVA		lles the m	DIVIO	Fei	bruary 4,2005
	10		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)		bruary 4,2005
	1		21 Data filed (Alparth Day York)	Kung thereby	NO MD	21187
	Sta Registr		31. Date filed (Month, Day, Year) 8 2005 ²² . Registrar's Signature	Agrical		

		-	For State Registrar	State of Maryland	d / Depa	rtment		•		_	03760
	Physicia /Medic	in al	1. Decedent's Name (First, Middle, Last) John Thomas V	Vhatley		45 00 7		2. Date of De Month	Day	2 05	3. Time of Death 745 A M
	Examino Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. 1	ast birthday) 2 Yrs.	If Under	own, or Location of Deat THORE Year If Under 24 Hrs Days Hours Min.	8. Date of Bi	rth ay, Year)	County of Deeth	place (State or Foreign
	Director mode:	or	Usuel Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc Baltir			76.10	. 192	.2-	10d. Inside City Limits 1 ☑Yes 2 ☐ No
	ath with the A 23s or 28s-	Funeral Director	10e. Street and Number 2508 W. Fovest Pa		Cocci,ii	10f. Zip	2126		10g. Citi	zen of What Cor	
900	within 72 hours after death with the Maryland ene. Han "netural", or tems 23a or 28a-f show the Maryled Exercities at the Maryland at the Mary	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ▼Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.3 Armed Forces? 1 Myes 2 ☐ No If Yes, Give Year or Dates:		/as Decede Yes, speci	ent of Hispanic Origin? (S fy Cuban, Mexican, Puer M No Specify:	Specify Yes or Note Rican, etc.)	0-	14. Race - Amer Black, White Specify: 12	
71010	ges 1 and 2 should be filled within 72 hours after death with the Marylan ges 1 and 2 should be filled within 72 hours after death with the Marylan to fleath and Mental Hygiene. If Health and Mental Hygiene is netterally, or thems 23s or 28s-f show or other traumetic event, the Marstell Exportment must be notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12th ayade	cation e completed) College (1-4or 5+) 24Ca r5		ind of worl	Occupation done during most of wo retired)	rking		nd of Business/1	ndustry
1	should be filed with and Mental Hygiene imarked other than	To Be C	17. Father's Name (First, Middle, Last) Johnny T. What 19a. Inform "Name/Relationship (Ty	tell	19h Mailin	Address	18. Mother's Na AMCI Street and Number or Re		rseij	•	in Code)
	Pages 1 and 2 shr nent of Health and int: If item 27 is m iny or other traum		A A A A A A A A A A A A A A A A A A A	NING 20b. Pl	3508 lace of Dispos	W. F	orest Park. of of place)	AVENUE	Ba 200. Lo	Ho MD	21216 Town, State
45%	permit. Pages 1 an Deportment of Heal Important: If Item 2 any njury or other		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Lo	udon		Address of Facility C. EV.	C8.05	-	altimore	
2	Physician /Medical		23a. Par 1. Enter the disease, or complish ck, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. Del	n. Do not ente	r the mode					Approximate Interval Between Onset and Death
S	Examiner	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence). Due to (or as a consequence)							
\sim	certificate be executed dring physician and use as the burial-transit	Ical Examiner	Cause (Disease of Injury that initiated events resulting in death) Last	Due to (or as a consequent	uence of):						
70	death death d for u	hysiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetel 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pre Other (spe				23d. Date of deli Month	very Day Year
27-6	S, T es tha gned I be det	by P	Part II. Other significant conditions col	ntributing to death but not resu	ulting in the un	derlying ca	use given in Part I.		tobacco u		the cause of death?
~ ·		e Completed	25. Was case referred to medical						opsy ormed? 2 X No	prior to d	topsy findings available completion of cause of
5.	99 (6) :=	To B	examiner? 1 Yes 2 No 27. Manner of Death Salatural 5 Pending	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28	Other: 4 Nursing I lc. Injury at Work?	ath (Check only Home 5 s es 28d. Describe	idence		rify)
R	To the Hospitel or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral or	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	M eet, factory	1 Yes 2 No	28f. Location City or To	(Street an own, State	d Number or Ru)	ral Route Number,
	To the Hospi within 24 hour To the Funer completely fill	Medical	(Check only 2 Medical Exemi	sicien: To the best of my kno iner: On the basis of examinal and manner stated.	wledge, death tion and/or inv	estigation,	in my opinion, death occ	e, and due to the urred at the time	, date and	place, and due	to the cause(s)
	10 10 10		29b. Signature and title of certifier 30. Name and address of person who ce	ompleted cause of death (from	1 23a) (Tuna 1		D2417	0		e signed (Monti	2,2005 1201
	10		E.Tso MD Rid	. Il-raina	828	N	Kutaw St	Baltin	M	MD 2	1201

VOID

CERTIFICATE

05-63761 VASIN

SEE

CERTIFICATE #

04-43/03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 005 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2133 PM Carole May Zablocki February /Medical 40. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Upper Chesapeake Medical Campus Bel Air Harford If Under 1 Year If Under 24 Hrs.

Months Days House Market 8. Date of Birth (Month, Day, Year)
Dec. 24, 1937 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2∏F Days 213-34-9620 67 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a. State 1 ☐ Yes 2 ☑ No Maryland | Baltimore Director Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21236 77 Open Gate Court U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Department of Health and 2 should be filed within 72 hours after coperation to Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, The Martiness Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Office Secretaru 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gordon Leroy McWilliams Anna May Ewina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. William Zablocki (husband) 77 Open Gate Ct., Baltimore, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【*Cremation 3 ☐ Removal from State *4 Donation 5 □ Other (Specify) Bayview Crematory 2/7/2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 Approximate Interval Between Onset and Death 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Povstctan End Stage Emphesema ZiveeKs disease or condition resulting in death) /Medical Due to (or as a masequence of) Examiner Antitrypsin Deficiency b. Alpha One Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Due to (or as a consequence of) Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? After this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ neu monic 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

395309

29a, Certifier

29b. Signature and title of certifier

State Registrar Mario

ompleted cause of death (Item 23a) (Type, Print) Zamera,

and manner stated.

29c. License number D40819

tix Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) February 3, 2005

Bel Air, md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar MEND TTEM #5 PER FH G840 2/14/05 JH Reg. No. 2. Date of Death Day **Physician** Josephine Marion Zmijewski 02 02 2005 13:52 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Hospital Bel Air Harford If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funera! 1 □ M 2 💢 F Months Days Hours Min. Yrs. Director Maryland 08/03/1937 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b, Count 10d. Inside City Limits 28e-f show traumatic evant, the Medical Examiner must be notified at 1 Yes 2 No Director Baltimore Kingsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or Herna 23a 11910 Bluestone Road Completed by Funeral 21087 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 ₩ Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within in and Mental Hygiene.
7 ia marked othar then " Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Raymond Paugh Frances Sibyl Marley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tam 27 11910 Bluestone Road - Kingsville, Maryland 21087 Raymond S. Smijewski (son) If itam 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 02/05/2005 | Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 6 E. F. Lassahn Funeral Home, P.A. again 11750 Belair Road - Kingsville, Maryland 21087 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deatl Immediate Cause (Final Physician disease or condition resulting in death) al au /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed 10 Duesa Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Vital Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Attanding P ision (After 1 Natural 2 Accident 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation Diractor: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide ä within 24 hours a To tha Funaral [Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 60

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

DON

32. Registrar's Signature

			For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of F tificate of		/lental Hygie Reg.	7007	03764
Die			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Ye	3. Time of Death
	ıysici. Medic		Jerome ACREE					January 2		1.4
Ex	kamin	er	4a. Facility Name (If not institution, give s	ŕ		4b. City, Town, or	Location of Death		4c. County of D	
			907 Guilford Aven 5. Social Security Number 6. Sex		(In use last historia)	Hager If Under 1 Year	stown If Under 24 Hrs.		Washin	
	neral ector		213-84-8809 ¹ \(\text{\tin}\text{\tetx{\text{\tetx{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\texi}\text{\text{\text{\text{\text{\texi}\text{\text{\texi}\text{\text{\texi{\texi}\text{\text{\tetx{\texi}\text{\text{\texi}\text{\text{\texi}\text{\text{\t	M 2 T F	(In yrs. last birthday) 42 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye April 13		Birthplace (State or Foreign Country) aryland
and			Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
Maryl	e pe	ō	1 1 17 1							1 ☑ Yes 2 ☐ No
the 1	noti	Director	Maryland Washing 10e. Street and Number	ton	наде	10f. Zip Code		10g.	. Citizen of What	Country?
h with	atte	al D	907 Guilford Aven	ue		2174	0		U.S.A.	,
deat	E TUR	Funeral		2. Was Decedent E	ver in U.S. 13. V		ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No-	14. Race - A	merican Indian,
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "netural", or Items 23a or 28e-f show	or other traumatic event, the Medical Executary must be notified at	by Fu	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	0	Yes 2X No	Specify:	rican, etc.)	Specify:	/hite, etc. Black
5-0 12 hou	leal	ted	15. Decedent's Educ	ation	16a. Deced	lent's Usual Occup	ation	. 168	o. Kind of Busine	
Maryland 21215-0036 d 2 should be filed within 72 hours at th and Mental Hyglene. ?? Is marked other than "netural", or	ne Med	Completed	(Specify only highest grade Elementary/Secondary (0-12) 8	College (1-4or 5+	life (OO NOT use retired	during most of work ()	ing	27	
D High	ent, L	CC	17. Father's Name (First, Middle, Last)	U		None	18. Mother's Nam	e (First, Middle, Mai	None den Sumame)	
arylance should be fand Mental Pand Mental Pand Mental Pand Mental Pand Mental Pand Pand Pand Pand Pand Pand Pand Pand	IC ev	To Be	Nicholas Arnette	Acree				elle (unk	,	
shou and M	umat		19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street a		al Route Number, Ci		e, Zip Code)
e, Ma 1 and 2 Health a	er tra		April Acree - Wif	е	907	Guilfor	d Avenue	Hagersto	own, Mar	vland
Itimore, it. Pages 1 ar itment of Hea	r oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Re	moval from State	20b. Place of Dispos				. Location - City	
Pages Pages ment of ent: If Its	ury o		'4 □Donation 5 □ Other (Specify)	miloval from State	Hagersto	wn Crema	tory 1/29	9/05 Ha	gerstow	n, Maryland
Baltimo	any in		21. Signature of Funeral Service License	M		. Name and Addres	. 1	Minnich Fu	~	
	eg Ot		1001//	11/cm			lson Blvd			aryland 21740
A0121 -			26a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused to cause on each line	he death. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
- Pπysid /Med			Immediate Cause (Final disease or condition resulting in death)		AIDS					155
Exam				Due to (or as a	consequence of):					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):					157
760, be executed sician and	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
O, exect an an	ırial-tr		resulting in death) Last	Due to (or as a	consequence of):					
68760, ificate be executed g physician and	s the bu	edical	d.							
	e as		IF FEMALE:							
Box 6 eath certifi	for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of 1 Live birth 2	Fetal death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
or the de	ched	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregnant at ti 9∏Unknown	me or death 5	Other (specify)				,
that the sed by	be deta	y Ph	Part II. Other significant conditions cont	ributing to death but	not resulting in the un	derlying cause give	n in Part I.	23e. Did tobacc	co use contribute	to the cause of death?
VITAL RECORDS, P.O. BOX itcian: The law requires that the death cert certificate has been signed by the attendin	nld be	ed by						1 🗆 Yes	2 □ No 3 □	Probably 4 Unknown
eco law re as bee	sho	Completed						24a. Was an	24b. Were	autopsy findings available
The lav	age :	Eo						autopsy performed	? death	
VITAL	ctor, p	Bec	25. Was case referred to medical examiner?				26. Place of Deati	1 ☐ Yes 2 ☐ 1 (Check anly one)	140	65 20 110
- Š	- B	2	1 ☐ Yes 2 XNo	spital: 1 🗌 Inpatient	2 ER/Outpatient	3□ DOA Othe	4 Nursing Ho	me 5 X Residence	6 Other (S	pecify)
ing ing	uneral	on:	27. Manner of Death 1'□Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c. Injury Work	?	28d. Describe how in	njury occurred	
or Attending after death. Director: After	the f	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	29a Place of Injur	At home form stre		res 2□No	00f Landing (Ct.)		O
DIVISION al or Attending tafter death. I Director: Afte	d in by	Certification:	4 Homicide determined	building, etc.	y - At home, farm, stre (Specify)	et, ractory, office		City or Town, St		Rural Route Number,
le Hospital de Hospital de Funeral D	/ fillec		29a. Certifier Certifying Physi	cian: To the best of	my knowledge, death	occurred at the tim	e, date and place,	and due to the cause	e(s) and manner	as stated.
he Hc n 24 l he Fu	pletel	edical	(Check only 2 Medical Examine one)	er: On the basis of e and manner state	xamination and/or invi	estigation, in my op	inion, death occurr	ed at the time, date	and place, and d	lue to the cause(s)
To the F within 24 To the F	COM	Ž	29b. Signature and title of certifier			29c. License			Date signed (Mo	
			ne				2323		1/28/5	
3H-1			30. Name and address of person who con Dr. Khalid Waseem,				n, Md. 21	740		
11 1	Sta	e	31. Date filed (Month, Day, Yeer)	32. Registrar		0	,	<u> </u>		
Re	gistra	ar	JAN 28 200	5 Same	A. da	entil.				

DHMH 17 Rev 1/2001

			For Stete Registrer	St	ate of Mary		artmen rtificate			and M		giene	/ 11 11 5	03765
	Dhysisi		1. Decedent's Name (First, M.								2. Date of De	ath Da	Year	3. Time of Death
	Physici /Medic	al			ALLEN		1 . 2				TAN	28	2003	
4	Examin	er	4a. Facility Name (If not institu						Location of	of Death			County of De	
			6405 Medfo 5. Social Security Number	rd Roa		yrs. last birthday)	Hur If Under		If Under	24 Hrs.	8. Date of Bir			
	Funeral Director		108-12-867	467.44		86 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Date 09/04	y, Year) /1 8		irthplace (State or Foreign Country) WYORK
			Usual Residence of Decedent											
	arylar show	<u>_</u>	10a. State 10b. Cou	,		c. City, Town or Lo	ocation	1	II 1	_ 1_				10d. Inside City Limits 1 ☐ Yes 2 🙀 No
	he Mi	ecto		cheste	r		101 7:-		Hur1	ock	1	10- 0#	izen of What (
	a of	늅	10e. Street and Number 6405 Medfo	rd Poa	a		10f. Zip	Code	216	<i>l</i> . 2			ted St	•
	ours after death with the Marylan raft, or Items 23a or 28e-f show Examiner must be notified at	Funeral Director	11. Marital Status	12. W	as Decedent Ever	in U.S. 13.	Was Deced	lent of Hi			cify Yes or No Rican, etc.)		14. Race - An	nericen Indian,
ထ	or Iter	五	1 Never Married 2 1	Married 1	rmed Forces? ∰Yes 2 □ No					, Puerto F	Rican, etc.)		Bleck, Wh	
21215-0036	72 hours after death with the Maryland netural', or liems 23a or 28e-f show lisal Examiner must be molified at	þ	3 ₩idowed 4 Divor	ced Y	Yes, Give ear or Dates:	41-78	1 ☐ Yes 2	21.0	Specify:				Specify:	White
5-0	72 h	Completed	15. Dece (Specify only hi	dent's Education phest grade con	1	16a Dece	dent's Usua kind of wor DO NOT us	l Occupa rk done d	ation during mos	t of workin	ng	16b. K	ind of Busines	s/Industry
121	within lene. then	mp	Elementary/Secondary (0-1	2) C	ollege (1-4or 5+)		ed S					U.:	S. Air	Force
	be filed with tal Hygiene d other the	e Co	17. Father's Name (First, Mide	dle, Last)	4	1124					(First, Middle	, Maiden	Sumame)	
Maryland	d be de de de de de de de de de de de de de	To B	Harry Ju	dson A	11en				Mina	a E1	la Mi	nor		
lan,	2 sh and and ls m		19a. Informant's Name/Relati Virginia L				•	,					r Town, State, GA 3	
	1 an Heali em 2 ther		20a. Method of Disposition	CICCITY		Ob. Place of Dispo	osition (Nan	ne of	Ţ		ate		cation - City o	
Į	@ ° = '>		1 Surial 2 ☐ Cremati		al from State	cemetery, cre Unity-Wa				02/0	05/05			Maryland
Baltimore,	nit.		`4 □Donation 5 □ Othe 21. Signature of Funeral Serv		Α.	_	_							Home, P.A.
ä	Dep Imp any		Michael	7. 4	tem-	2	16 N	. Ma	ain S	St.,	Fede	ral:	sburg,	MD 21632 Approximate
	Physician /Medical Examiner	er	23a. Pent. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. They leading to mme fists	List only one car	Due to or es a co	msequence of):	IAN				, roopilatory a			Interval Between Onset and Death
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1										
ó	an an		resulting in death) Last	с.	Due to (or as a co	nsequence of):								
8760,	ate be executed hysician and the burial-transit	lical		d.										
.O. Box 6	at the death certificate be executed by the attending physician and trached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 4	yes, outcome of p □Live birth 2 □ □Pregnant at time □Unknown	Fetal death 3	⊒Ectopic pro □ Other (sp						23d. Date of d Month	elivery Day Year
Δ.	quires that n signed b uld be deta	þ	Part II. Other significant con	ditions contribu	ting to death but no	ot resulting in the u	ınderiying ca	ause give	en in Part I.		23e. Did t			to the cause of death? Probably 4 □Unknown
Vital Records,	The law requires that the cate has been signed by th page 2 should be detache	Completed									24a. Was auto perfo 1 🗆 Yes		prior to death?	
Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to med examiner?	dical Hospit	al:			Othe	0.00		(Check only o			
ot o	Phys this ral di	To	1 Yes 2 No		1 Inpatient la. Date of Injury	2 ER/Outpatie		<u>'^</u>	4 [140	rsing Hon	ne 5 Resi 28d. Describe		6 ⊡Other (Sp v occurred	pecify)
	ding h. After funer	tion	1 Anatural 5 ☐ Pe		(Month, Day Ye		М	8c. Injury Work	<br Yes 2 🔲				•	
Division	ol or Attending atter death. I Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Co	uld not be ermined 28	te. Place of Injury building, etc. (5	At home, farm, st Specify)	reet, factory	r, office		2	28f. Location (City or To			Rural Route Number,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Gert (Check only one) 2 Medi	cal Exeminer: (n: To the best of m On the basis of exa and manner stated	amination and/or in	th occurred evestigation,	at the tim	ne, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) date and	and manner and du	as stated. ue to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of cer	tifior	2				e number					nth, Day, Year)
)			Most	alil	e no		-C	26	38	8		JA	U 28	7005
_			30. Name and address of per	son who comple	ted cause of death	(Item 23a) (Type, 302 Coll	Print)	1:fe	מלומ	K	Md ?	216	43	7005
	Sta Registi		31. Date filed (Month, Day, Y	2 2005	32/Registrar's	Signature	out)							

			1 - For State Registrar	State of Maryl	and / Depa	artment rtificate	t of Heal	th and I a <i>th</i>		giene Reg. No.)5 (3766	
	Physici		Decedent's Name (First, Middle, Last) Virginia Rose Au	ıbrey					2. Date of Dea Month	Day	Year CC5	3. Time of Death	м
	/Medic Examin		4a. Facility Name (If not institution, give s 787 Oak Stump Dr				Town, or Loca			4c. Count	ty of Death		
	Funeral Director		Social Security Number 6. Sex	7. Age (In	yrs. last birthday) Yrs.	If Under Months		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day Sep. 2	n	9. Birthpl Coun	undel lace (State or Foreig try) PA	gn
ryland	how		Usual Residence of Decedent 10a. State 10b. County MD Anne Aru		. City, Town or Lo		7 .	77	-			Od. Inside City Limit	
th the Ma	or 28a-f s e natifies	Director	10e. Street and Number	nder		10f. Zip	lersvi	11e		10g. Citizen of	What Coun	1 ☐ Yes 2 反 N try?	0
1 215-0036 within 72 hours after death with the Maryland	and Mental Hygiene. Is marked other than "natural", or liems 23a or 28a-f show raumatic evant, the Michigal Examinatic evant, the multiled at	Funerai	1 Never Married 2 Marned	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Was Deced	ify Cuban, Me	ic Origin? (S xican, Puert	pecify Yes or No- o Rican, etc.)		USA ace - America ack, White, e		
Maryland 21215-0036	ane. than "natural" se Medical Ex	Completed by	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates: cation completed) College (1-4or 5+)	(Give	kind of wor. DO NOT us	l Occupation k done during e retired) esperso		king	16b. Kind of E		ustry	
yland 2	Mental Hygie arked other t atic evant, IL	To Be Co	17. Father's Name (First, Middle, Last) Charles Leo McCur.	ry			18. A	Mother's Nan	ne (First, Middle, Ann Mul]	.en	me)		
≥ ⊽:	5 7 7		19a. Informant's Name/Relationship (Type Suzanne M. Castle) 20a. Method of Disposition	berry/Daugh	ter 787	Oak i	Stump I		ral Route Numbe Nillers Date		MD 2	21108	
	Department of Heal Important: If Itam 2 any injury or other once.		1 Burial 2 Stremation 3 Re 1 Donation 5 Other (Specify) 21. Six sure Funeral Service Licen		Metro (remat	ory	_	. 21, 2005 . A. Seve	Baltim		MD meral Homa	_
¥.	ysician	V 7	2 8 art Enter the disease, or complict shoc or heart failure. List only on mmediate Cause (Final	e cause on each line.	death. Do not ent	er the mode	of dying, suc	h as cardiac	or respiratory arr	est,	CK, MIL	21146 Approximate Interval Between Onset and Death	_
//	Medical aminer parisher aminer parisher aminer parisher aminer parisher aminer	dicai Examiner	disease or condition resulting in death) Sequentially list conditions, lary lagory to meet allocate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):	<i>A KC//</i>		- UN	WELSN	PRIM	7		
. Box 6	by the attending physi stached for use as the l	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	Ectopic pre Other (spe					ate of deliver	y Day Year	
Hecords, P.O.	gned e de		Part II. Other significant conditions conf	tributing to death but not	4 4		use given in P	Part I.		pacco use con	tribute to the	cause of death?	n
	icate has been si r, page 2 should l	Completed by			/ /	-			24a. Was a autops perform	ned?	death?	sy findings available pletion of cause of □ No	9
	this certificate al director, pag	To Be	1 192 5 15440	-	2 ☐ ER/Outpatien		Other: 4		th Check on on	-	ner (Specify)		-
DIVISION OF		Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year		M	Work?	2 N o	28d. Describe ho				
DIVISION To the Hospital or Attanding	za nours aner o Funaral Direc stely filled in by		4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	ecify)				28f. Location (SI City or Town	n, State)			
the Hos	within 24 nd To the Fun completely (Medical	one)	ician: To the best of my er: On the basis of exam and manner stated.	knowledge, death	estigation, i	in my opinion,	death occur	red at the time, d	ate and place,	and due to t	the cause(s)	
O	10 COC		29b. Signature and title of certifier Success 30. Name and address of person who con	ms		29c.	D 5 7	531	2	9d. Date signe	a (Month, D	ay, Year)	
			30. Name and address of person who con Mehet Negr,	mpleted cause of death (ltem 23a) (Type, I	Print)	24.1	mill	ersvil	1e m	102	1108	
	Sta Registr	_	31. Date filed (Month, Day, Year)	SZ Bystiai S Si	gnature	~	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Month 2005 BESSIE NOCK BOWEN 23 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prinsula Shully ar If Unger 24 Hrs. legional Medical Cente Willmill 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Days Min. 1 ☐ M 2 XF Months Hours 93 MD 218-20-6726 6/28/1911 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ¥Yes 2 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 300 Lemmon Hill Lane 21801 **USA** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Specify: 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Farmer Farming 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sarah Hadder Gordon Nock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sally Anne Molnar 7967 Libertytown RD Berlin, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Bowen Cemetery * 4 ☐ Donation 5 ☐ Qther (Specify) 1/27/05 Newark, MD 22. Name and Address of Facility The Burbage Funeral Home 21. Signaur Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OCHRDIAL INFARCTION Due to (or as a consequence of): CARDIOVASCULAR ATHEROSCIOROTIC 5 A-12 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Discass of injury] Due to (or as a consequence of): Cause (Disease or injurithat initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 1 ☐ Yes 2 🗓 📉 Yo 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

10a, State

Examiner

Funeral

Director

nust be notified at

other treumatic event, if a Madical Examiner

Maryland

Baltimore,

Box 68760

P.0.

Records,

of Vital

Division

Pages 1 and 2 should be f nent of Health and Mental I

item 27

= 5 Department of Importent: If any injury or once

items 23a

ŏ

Completed by Funeral Director

Be

ပ္

Examiner Physician/Medical 5 Completed Be 2

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 T Homicide

(Check only one)

sician and burial-transit that the death certificate be executed attending p has this Certification: After Hospital or Attending death. Director: within 24 hours a To the Funeral I

fo the

State Registrar

icai

29b. Signature and title of gertifier

29c. License number

1 ☐ Yes 2 ☐ No

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 05

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SWIERKOSZ MD Phol Salisbury, Md 2180 1008. Called St 31. Date filed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

JAN 2 5 2005

5 Pending investigation

6 Could not be

determined

			1- For Amend Item 9 Registrar	State of A per fh G	larylar 844 6	nd/Depa -7-05 Cei	artmen tas rtificat	t of H e of L	ealth a	and M	lental H	ygien Reg. N	e 200	5	03768
П	Physici	-	1. Decedent's Name (First, Middle, La	,							2. Date of D		ay \	,	3. Time of Death
	/Medi Examir	cal	MATTHEW EINAR 4a. Facility Name (If not institution, giv				4b. City,	Town, or	Location	of Death	JANUA	ARY			8:50 A M
			National Institut	es ofHeal	th			esda	l_				Montgo	omerv	
Н	Funeral		5. Social Security Number 6. S	ex 7. A 120 M 2 □ F	ge (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	irth ay, Year)	9. Birthplac	Californi
	Director		545-77-0251 Usual Residence of Decedent 10a. State 10b. County	A -	32						6-25-			Jtah	
	Maryla f sho	ō	KY			ty, Town or Lo L isvill								10d	I. Inside City Limits 1 ☐ Yes 🎖 ☐ No
	n the or 28e	irec	10e. Street and Number			10 1111	10f. Zip	Code				10g. C	itizen of Wh	at Country	
	ath wil	raiD	2901 Abigail Driv	e #1			402	205				USA			
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygene. Is marked other then "natural", or items 23a or 28e-1 show eumatic event, It's Modical Executivations to notified at	by Funeral Director	11. Marital Status 1 □ Never Married 27□ Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 X If Yes, Give	:?] No	1	Was Deced f Yes, spec 1 ☐ Yes 2	rfy Cubar	spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Black, Specify: V	White, etc	c.
8	2 hour		15. Decedent's Ed	Year or Dates ducation		16a. Deced	fent's Usua	I Occupa	tion			16b K	(ind of Busin		
21215-0036	ithin 7 16.	Completed	(Specify only highest gra	de completed) College (1-4or	5+)	(Give	kind of wor DO NOT us	k done di	urina most	of worki	ng	100.1	and of Busin	11033/11/003	sti y
	filed with Hygien other the	S	17. Father's Name (First, Middle, Last)	5+		Thera	pist						emp1	oyed	
Maryland	d be fantal Fred of	o Be									(First, Middle	e, Maider	n Sumame)		
3	should ind Men	오	Einar Bergstedt 19a. Informant's Name/Relationship	Type, Print)		19b. Mailin	a Address		Conni		ord I Route Numb	ner City (or Town St	ate Zin Co	ode)
ž	7 E N 3		Ingjerd Bergstedt	- Wife							ouisvi				
ore	ges 1 and 2 should it of Health and Mer I I item 27 is marke or other treumatic		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	C	lace of Dispos	sition <i>(Nam</i>	e of	!	D	ate		ocation - Cit		
altimore,	t. Pag rtment rtent: rjury o		`4 □Donation 5 □ Other (Specify	")	Men	atch I norial			0	1-26	-2005	Sal	t Lake	e Cit	y, Utah
Ba	permit. Pages 1 and Department of Healt Importent: If item 2 any injury or other once.		21. Signature of Funeren Services Electric	rshall		4	<u> 217 9</u>	th S	t. N	.W.	Home, Washi	ingto	on, D.	.C. 2	0011
			23a. Part Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	plications that cause one cause on each	d the death	h. Do not ente	er the mode	of dying	, such as	cardiac o	r respiratory a	rrest,		Ar	oproximate terval Between nset and Death
	Physician /Medical		disease or condition resulting in death)	a. Meta Due to (or as	stat		Mano	ma	<u> </u>					34	rs, 5 mas
	Examiner				a consequ	uerice or):									
	og is	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):									
•	xecute and al-tran	Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequ	ience of):									
8760	certificate be executed dding physician and tse as the burial-transit	dicai E		d	,										
9	rtificate ng phys as the	Medi	IF FERMI	<u> </u>											
ă.	death e atter id for u	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal	death 3 🗆	Ectopic pre Other (spe						23d. Date o Month	f delivery Da	y Year
مر ت	res that igned by be deta	by Ph	Part II. Other significent conditions co	ontributing to death t	out not resu	ulting in the un-	derlying ca	use given	in Part I.		23e. Did t	obacco L	ise contribu	te to the c	ause of death?
Space	law requires that the as been signed by th 2 should be detache	ted b									10	Yes 2	No 3	☐ Probably	4 □Unknown
ľ	The ate h page	Completed										an psy ormed? 2 No	prior	to comple	findings available etion of cause of
<u> </u>	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:							(Check only o				
on of	yd Sic	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		ER/Outpatient 28b. Time of Injury		c. Injury a Work?	4 LI Nur	2	le 5 ☐ Reside l			Specify)	
DIVISION	To the Hospital or Attending Pl within 24 hours after death. To the Funerel Director: After the Completely filled in by the funera	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, et	ury - At ho c. (Specify	me, farm, stre	et, factory,				8f. Location (S City or Tox	Street an vn, State,	d Number o }	r Rural Ro	oute Number,
	ne Hospit 124 hour ne Funere	edicai (29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	rsicien: To the best iner: On the basis o and manner st	t examınatı	wledge, death ion and/or inve	occurred at estigation, i	the time n my opir	, date and nion, death	place, a	nd due to the d at the time,	cause(s) date and	and manne place, and	or as stated due to the	d. cause(s)
	Within Comp	Me	29b. Signature and title of certifier	2 /			29c.	License r	number			29d. Dat	e signed (M	fonth, Day	Year)
)	16		Jumba &	sel ne)			160	103			1/	20/05	5	
	ye		30. Name and address of person who c		leath (Item			mer.							
	Stat Registra		31. Pate filed (Month, Day, Year) JAN 2 6 2005	32. Registr			CEN'	TEK	DRIV	VE,	BETHE	SDA	MD 2	20892	2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03769 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 6:25A M Januara 22, 2005 BROWN 5512 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Community Prince Doctors
Social Security Number Lanham If Under 1 Year | If Under 24 George ge (In yrs. last birthday)

Days

Hours

Min

Months

10f. Zip Code

10c. City, Town or Location

Physician /Medical **Examiner** Funeral Director death with the Maryland ò the Medical Exam nature 1 and 2 should be filed withi Health and Mental Hygiene. em 27 Is marked other than other treumatic event, t of Health a: If item 27 ls Pages 1 ō

Be Completed by Funeral Director

1 - For State Registrar

10a. State

Usual Residence of Decedent

1 Never Married 2 Married

3 ₩idowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

12

David

in the past 12 months? 1 ☐ Yes 2 ☐ No

9 🗌 Unknown

1 ☐ Yes 2 No

1 Natural 2 Accident

3 Suicide

4 Homicide

Makyland 10e. Street and Number

11. Marital Status

10b. County

Maryland 21215-0036 Baltimore,

Physician /Medical **Examiner**

burial-transit to the Hospital or Attending Physicien: The law requires that the death certificate be executed use for detached page 2 director, after death.

Box 68760

Division of Vital Records, P.O.

by Physiclan/Medical Examiner Completed Be Certification: To filled in by Medical

20a. Method of Disposition Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 27. Manner of Death 29a. Certifier

within 24 hours a dompletely 29b. Signature and life of certifier 30. Name and address of person who completed cause of death (Item 300 State

31. Date filed (Month, Day, Year) JAN 2 6 2005

investigation 6 Could not be determined

32. Registrar's Signature

United 20746 12. Was Decede Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Armed Forces?
1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ₩ No If Yes, Give Year or Dates: Specify Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) WORKER Domestic 18. Mother's Name (First, Middle, Maiden Sumame) Shuler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 19a. Informant's Name/Relationship (Type, Print) Nakkow lent Daughten 50 3 Name of cemetery, crematory or other place) 20c. L cation - City or Town, State DR 1 Burial 2 □ Cremation 3 □ Removal from State Cheltenham 4 □ Donation 5 □ Other (Specify) Veteran Feb 32005 PODE 5538 21. Signature of Funeral Service Licensee Funeral Homes 5533 Marlbore Pike 747 Like

8. Date of Birth (Month, Day,

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PSIL Due to (or as a consequence of): Due to (or s a consequence of): Due to (or as a consequence of)

1 M 2 T

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

9☐ Unknown

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

9. Birthplace (South

10g. Citizen of What Country?

10d. Inside City Limits 1 es 2 No

Approximate Interval Between Onset and Death

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 ☐ Yes 2 2 No 26. Place of Death Check onli one

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

D45664 SPINDER SINGH, M.D

Registrar

			1 - For State of Maryland		artment of H			giene ()	05	03770
	Physici	20	1. Decedent's Name (First, Middle, Last)				2. Date of De. Month	Day	Year	3. Time of Death
	Physici: /Medic		Evelyn Virginia Boswell				January	y 21, 2		11:40 p ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Beltsvil		h		ity of Death	arao la
	Comment		4300 Briggs Chaney Road 5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs		th		lace (State or Foreign try)
	Funeral Director		578-46-4007 1□M 2☒F 93	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year) 2, 1911	Wash	nington, DC
1	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, T	oum or Lo	antion	<u> </u>				
	shov	5							10	0d. Inside City Limits 1 X Yes 2 No
	the N	Funeral Directo	Maryland Prince George's Belts 10e. Street and Number	3V111	.e 10f. Zip Code			10g. Citizen of	f What Coun	
	as or	١	4300 Briggs Chaney Road		20705			U.S.A.		,.
	death ms 2	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No		ace - America	
98	or Ite	y Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give		1 □ Yes 2 🗖 No		to riloan, etc.,	Spec	lack, White, e :ify: Whi	
21215-0036	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show dical Examinat must be notified at	ed by	3 ☑ Widowed 4 □ Divorced Year or Dates:	62 Door	dent's Usual Occupa	ntion			***************************************	
5	in 72 " nal	Completed	(Specify only highest grade completed)	(Give	kind of work done of NOT use retired	ation during most of wo i)	rking	Ibb. Kind of	Business/Ind	ustry
212	d with giene ir thai	mo	Elementary/Secondary (0-12) College (1-4or 5+)	Homen	naker			Own Hor	me	
bu	al Hygin other	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle,	Maiden Suma	ıme)	
yla	ould b Ment arked atic e	To	Robert Leaman				Thomas			
Maryland	12 sh h and 7 Is m rraum				g Address (Street a Briggs C			•		
e,	1 and Healti em 2		, , , , , , , , , , , , , , , , , , , ,		sition (Name of natory or other place		Date Delt	20c. Location	•	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		TEX DUTIAL 2 CHARMACION 3 CHARMOVAL ITOM STATE		natory or other plac oln Cemet		5/2005		•	
뵱	ortme corten injur		21. Signature of Euroral Service Licensee		. Name and Addres					
ñ	Depo Impo any		101373	3 1	4739 Balt	imore Av	enue, Hy	merar ⁄attsvi	11e, M	D 20781
			23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dyin	g, such as cardia	c or respiratory ar	rrest,		Approximate Interval Between
H	Priysician		Immediate Cause (Final disease or condition	HOY	1. Aca	for -				Onset and Death
1	/Medical Examiner		resulting in death) Due to (or a consequent	ce of):	7	1.				7- //
	_xaiiiiioi	7	Sequentially list conditions, b. Due to to as a consequent	ce of):	Demen	tra			- 7	rew yours
	uted I Insit	mine	cause. Enter Underlying Cause (Disease or injury	0.00						
Ć,	be executed sician and burial-transit	Examine	that initiated events resulting in death) Last C. Due to (or as a consequent	ce of):						
8760,	death certificate be executed e attending physician and d for use as the burial-transit	edlcal	d							
9	artifica ing ph e as th	Med	IF FEMALE:							
Вох	eath certific attending p for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	ath 3	Ectopic pregnancy				Date of deliver Month	ry Day Year
0	e ± ec	ysic	1 ☐ Yes 2 ☒ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	1 5	Other (specify)					,
۵.	g p g		Part II. Other significant conditions contributing to death but not resulting	ng in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use col	ntribute to the	e cause of death?
Vital Records,	requires been signe hould be	d by	Recent evaluation for Gas	uare	ne.		1 🗆 1	Yes 2/10 No	3 🗌 Proba	ably 4 Unknown
CO		Completed	,	0			24a. Was		. Were autop	osy findings available
Re	The age	mo					autop perfo 1 ☐ Yes	rmed?	death?	npletion of cause of 2 No
ita	stcian: 1 certifical rector, p	BeC	25. Was case referred to medical examiner?			26. Place of De	ath (Check only o			
of V	ys G :5	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER		t 3□ DOA Oth	4 Li Nursing F	lome 5 Resid)
		ertification:	1 Natural 5 ☐ Pending (Month, Day Year)	b. Time of Injury	Worl	/at k? Yes 2 ⊟No	28d. Describe h	now injury occu	ırred	
Division	ten deat tor: the	licat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home	. farm. str		163 2 110	28f. Location (S	Street and Nun	nber or Rural	Route Number.
οį	Dir.	erti	4 Homicide determined building, etc. (Specify)	1	1/A		City or Tov	wn, State)		
	Hos Fur h	edical C	29a. Certifier (Check only one) Check only one)	dge, death and/or in	n occurred at the time vestigation, in my of	ne, date and place pinion, death occ	a, and due to the urred at the time,	cause(s) and n date and place	nanner as sta , and due to	ated. the cause(s)
	To the To the complet	Me	29b. Signature and title of certifier		29c. License	number		29d. Date sign	ed (Month, E	Day, Year)
}	(10)		Many D. Kirera-Kine,	MO	D00	40904	-	JANELAR	ey 29	7,2005
_	ge		30. Name and address of person who completed cause of death (Item 23) NANCY RIVERA - KING, M.D. P.		Print)	EDGEL	VATER	JANEIAN .	2103	7
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 6 2005	E)	7			· <u>-</u>		

State of Maryland / Department of Health and Mental Hygiene 1 - State Ragistras Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Belva Marie January 23, 2005 Biery 07:30 a.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6027 67th Place Prince George's Riverdale If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Director Yrs. 83 175-14-2593 Nov. 13, 1921 PA Usual Residence of Decedent with the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic evant, the Medical Examiner must be notified at Directo 1 TyYes 2 □ No Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or itams 23a 6027 67th Place 20737 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 and 2 should be filed within 72 hours after of teath and Mental Hygiene. om 27 is marked other than "naturel", or itan Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes ② No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Completed by Specify: 3 √Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Book Keeper Central Intelligence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Willey Crestino Pepe 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a important: If item 27 is any injury or other trau once. 6027 67th Place, Riverdale, Maryland Pamela K. Biery, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ^ 4 □ Donation | 5 □ Other (Specify) Fort Lincoln Cemetery Jan. 29, 2005 Brentwood, Maryland 21. Signature of Funeral Salv 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dayse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Metastatic Laryngeal Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physicien Box 68760, Physician/Medical as use use IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 0 in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown q Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed Division of Vital 2 No 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After t 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide thin 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal completely (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifie 29c. License number 2 29d. Date signed (Month, Dav. Year) 章品 身 MD 30807 January 25, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christine Puchalski 2150 Pennsylvania Avenue NW, Washington, DC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/200:

			1 - For State Registrar	state of Maryland / D	epartment of F Certificate of I	lealth and Mei <i>Death</i>			03772
			Decedent's Name (First, Middle, Last)		Commonto or		Reg. Date of Death		3. Time of Death
	Physici /Medic			CATHERINE BOWE	RS	Ja	muary 2.	Day 2005	6:55 A M
	Examin	er	4a. Facility Name (If not institution, give stre	et and number)		Location of Death		4c. County of Death	
-	-	-	College View Center 5. Social Security Number 6. Sex	7. Age (In yrs. last birtl	Freder:	1 11 11 11 11 11 11 11 11 11 11 11 11 1	Date of Birth	Frederic	Ace (State or Foreign
Į.	Funeral Director				rs. Months Days	Hours Min.	(Month, Day, Ye	ar) Coun	try)
	/land		10a. State 10b. County	10c. City, Town	or Location			10	Od. Inside City Limits
	a-f sh	ctor	Maryland Frederic	k Freder	rick				1X Yes 2 □ No
	ith the	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Coun	try?
	death with the Maryland ms 23a or 28a-f show Errual Le riculfied at	erai	700 Toll House Avenu		2170			U.S.A.	
350	d within 72 hours after death with the Marylan tiene. r than "naturel", or items 23a or 28a-1 show the Medical Examinat man be notified at	by Funerai	11. Marital Status 12. 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No	lispanic Origin? (Specifi an, Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - America Black, White, a Specify: Whi	etc.
2-003p	72 hou		15. Decedent's Educat	on 16a.	Decedent's Usual Occup	ation	16b	. Kind of Business/Ind	
Z	within 72 ene. than "nai	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retired				
7	filed w Hygier other th	S	12 17. Father's Name (First, Middle, Last)		Homemakeı		Ton Mindello No. 1	Own Hor	me
and	be de la la la la la la la la la la la la la	To Be	William Adam Bruchey	7		18. Mother's Name (F Mary Stott		ien Sumame)	
2	should and Men marka umatic	Ĕ	19a. Informant's Name/Relationship (Type,		Mailing Address (Street		<u>-</u>	ty or Town, State, Zip	Code)
<u>≅</u>	42 15 2 15 15 15 15 15 15 15 15 15 15 15 15 15		William Bruchey (Ne		Carriage La				·
ore,	of He of He Mitsm or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Rem	oval from State cemeter)	Disposition (Name of y, crematory or other place		200	. Location - City or To	wn, State
шшог	tment tant:		*4 □ Donation 5 □ Other (Specify)	Mt. O	livet Cemete			ederick, Ma	
Palt	permit. Pages 1 and Department of Healt Important: If itsm 2 any injury or othar once.		21. Signature of Fendial Service Liposee	celey f	22. Name and Addres ROBERT E. I 1201 NORTH	MARKET ST.	. FREDE	AL HOMES, I	P.A. 1701
	Physician /Medical Examiner		23a. Part1. En er the disease or million shock, or heart in e. List only one of immediate Cause (Final disease or condition resulting in death)		ot enter the mode of dyin	ig, such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
	ped lisit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter I Inderlying. Cause (Disease or injury	Due to (or as a consequence o	of):				
Ď,	tificate be executed g physician and as the burial-transit	i Examiner	that initiated events c resulting in death) Last	Due to (or as a consequence o	if):				
08/pn	physia physia	edicai	d						
O. BOX C	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of deliver Month	ry Day Y <i>e</i> ar
ras, r	requires that een signed b hould be deta	by P	Part II. Other significant conditions contrib	uting to death but not resulting in	the underlying cause give	en in Part I.		co use contribute to the	ably 4 Unknown
Records	The far ate has page 2	Completed					24a. Was an autopsy performed	? prior to come death?	sy findings available apletion of cause of
VITA	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	2-1		26. Place of Death (C			
0	hys his	T.	1 ☐ Yes 2 ☐ No Hos 27. Manner of Death	Dital: 1 Inpatient 2 ER/Out 28a. Date of Injury 28b. Ti		4 Mursing Home		6 ☐Other (Specify,)
DIVISION	Jing After fune	ertification:	1 Natural 5 Pending 2 Accident investigation		jury Wor	yat k? Yes 2 □ No	. Describe how in	njury occurred	
	spitel or Att ours after di naral Diract filled in by t	O	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f.	Location (Street City or Town, St	and Number or Rural ate)	Route Number,
	To the Hospitel or Attand within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physici 2 Medical Exeminer	en: To the best of my knowledge, On the basis of examination and and manner stated.	death occurred at the tin for investigation, in my o	ne, date and place, and pinion, death occurred a	due to the cause at the time, date	P(s) and manner as sta and place, and due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier		29c. License		29d.	Date signed (Month, D	Day, Year)
	7			10		1912		1/21/00	5
	~ /		30. Name and address of person who comp	1564_07055Um	rown 7144	FREDERIL	h mp	21702	
	Sta Registr		31. Date filed (Month, PAY) 6 20(5 32. Registrar's Signature	Book				

			For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of H	lealth and M Death		ene 0 0 5	03773
	Physici		1. Decedent's Name (First, Middle, Last)	BISHOF	>			2. Date of Death Month JANU AR	Dav Year	3. Time of Death $2 40 \text{ fm}$
	/Medio Examin		4a. Facility Name (If not institution, give s ST MARY'S HO.	SPITAL			Location of Death		4c. County of Dea S7 MA	275
	Funeral Director		5. Social Security Number 6. Sex 577–60–1747 Usual Residence of Decedent	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JULY 15	Year) 9. Bin Co ,1925 VE	thplace (State or Foreign buntry) RMONT
	within 72 hours after death with the Maryland ane. than "natural", or itams 23e or 28e-f show the Medical Examinar rust be notified at	by Funerai Director	10a. State 10b. County MD CHARLES 10e. Street and Number 1551 BRYAN COURT		y, Town or Lo	10f. Zip Code	2	10	g. Citizen of What Co	
9:00-	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or itams 23e or 28a-1 show any njury or other traumatic event. Its Medical Examinat rual be notified at once.	ted by Funera	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edur	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	16a. Dece	f Yes, specify Cuba 1 ☐ Yes 2 ☑ No dent's Usual Occup		Hican, etc.)	14. Race - Ame Black, Whit Specify: W	e, etc. HITE
21215-0036	filed within 7; Hygiene." other then "n ant, the Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	SECRE	DO NOT use retired			DEPT, OF J	USTICE
Maryland	2 should be filed withir and Mental Hygiene. Is markad othar than aumatic evant, the M	To Be	17. Father's Name (First, Middle, Last) THEODORE BISHOP 19a. Informant's Name/Relationship (Ty,	na Print)	19h Mailir	og Address (Street		Y RUSHFO		Zin Code)
	ages 1 and 2 should be sho		RONALD E. BISHOP / 20a. Method of Disposition 1 Burial 25 Cremation 3 R	SON 20b. Femoval from State	29920 Place of Dispo	CHICKASA esition (Name of matory or other place	AW PLACE N	MECHANICS Date 2 UARY	SVILLE, MD Oc. Location - City or	20659 Town, State
Baltimore,	permit. Pages: Department of H Important: If its any injury or of		21. Signature of Funeral Service License	L Solo MOO	641 3	2. Name and Address 0195 THRE	EE NOTCH 1	INSFIELD- RD. CHARI	LOTTE HALL	NL.HME.,P.A. , MD 20622
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (EMIA Juence of): INF	ARCTI			st,	Approximate Interval Between Onset and Death Hours Hours Fours Pays
. Box 68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	by Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{ZNO} \)	Due to (or as a consect 3. If yes, outcome of pregn. 1	ancy	□Ectopic pregnancy	,		23d. Date of de Month	ivery Day Year
ds, P.O.	uires that the death signed by the atter d be detached for u	by Phys	9 ☐ Unknown Part II. Other significant conditions cor	9□ Unknown ntributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Vital Records,	The law requirate has been sipage 2 should	Completed						24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
Division of Vita	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Diractor: After this certificate ha completely filled in by the funeral director, page	To Be	27. Manner of Death 1 Manual 5 Pending 2 Accident Investigation	lospital: 1 Depatient 2 Z 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injur Wor	er: 4 🗆 Nursing Ho	n <i>(Check only one</i> me 5 ☐ Resider 28d. Describe hov	nce 6 Other (Spe	cify)
Divis	Hospital or Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	fy)			City or Town,		
	To the Hospital or Attanowithin 24 hours after death To the Funeral Director:	Medical		sician: To the best of my knoner: On the basis of examination and manner stated.			pinion, death occur	red at the time, da		e to the cause(s)
9 (4	RIN		30. Name and address of person who co		т 23a) (Туре. Е НОС	Print) P17A1 L	1178 -EONARD	TOWN.	MARYLANI)
-	Sta Regist		31. Date filed (Month) AN 2 6 20	32. Registrar's Sign:		fords				

DHMH 17 Rev 1/2001

amend item, #1, perMD, G845, 7/1/105 IT
State of Maryland / Department of Health and Mental Hygiene

1- State Amended 1/26/05 items #10C, 10f 112 Amended 1/26/05 Rag. No. Louis Harris Callaway 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician LOUIS HARRIS TANUARY 2005 05:18 AM 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. Min. Months Days Hours Min. JAN - 26, 1918 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 222-07-5244 86 Director Mary1and Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "neturel", or items 23e or 28e-f shot treumatic event, the Wedical Examination ust be modified at 1 ☐ Yes 2 No GEORGETOWN DELAWARE SUSSEX SEAFORD -Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code With 19947 19973 USA 16784 SEASHORE HIGHWAY Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NDT use retired) (Specify only highest grade completed) EARTH MOVING al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) PRESIDENT & CEO COMPANY 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fil tment of Health and Mental H tant: If item 27 is marked ot Be DANIEL HENRY CALLAWAY ELIZABETH WARREN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANK H. CALLOWAY SON 26734 RIVER ROAD, SEAFORD, DE 19973 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. ODD FELLOWS CEMETERY 01/27/05 SEAFORD, DELAWARE ^¹ 4 □ Donation 5 □ Other (Specify) M00866 21. Signature of Funeral Sec-PARSELL FUNERAL HOMES HARDESTY CHAPEL 202 LAWS STREET, BRIDGEVILLE, DE 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complete the complete t s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examine certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Tyes 2[] No Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one)_ Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ö Hospitel within 24 hours a To the Funerel I 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier dain JANUARY 23, 2005 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MARYLAND CHARLES GALANIS 600 NORTH WOLFE STREET 32. gistrar's Signature 31. Date filed (Month, Day, Year)
JAN 2 6 2005 State Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** GEORGE BERTRAND CROPPER 20 2005 7:15 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1409 Jacqueline Ave. Ocean City Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex Birthplace (State or Foreign Country) 1**X** M 2□ F Yrs. Director 214-34-6090 96 6/16/1908 MD Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23s or 28e-f show the Medical Exercipations be redified at 1XYes 2 □ No Director Ocean City MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1409 Jacqueline Ave. 21842 **USA** filed withIn 72 hours after death ' Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify ģ Specify: White 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than College (1-4or 5+) Elementary/Secondary (0-12) Owner/Operator Concrete Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill timent of Health and Mental Hant: If Item 27 is marked off jury or other traumatic even Be Harry James Cropper Susan Harriett Hickman ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline C. Insley 601 Tony Tank Lane Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Pag Department Important: It any injury o * 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Cemetery 1/22/05 Berlin, MD 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St. Berlin, MD Justal Part Enter the disease, or compli-shock, or heart failure. List only on tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death cause on each line Immediate Cause (Final disease or condition **Physician** eressa /Medical resulting in death) Due to (or as a consequence of): Examiner Theroschosos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a signed t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 0 No To the Hospitel or Attending Physicien: filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2/PNo 2 ER/Outpatient 3□ DOA this 27 Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 1 Matural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ux Cle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury TANK La Phil.p A. I JR 60 100 NS/EY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **JAN 25** 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - Stata Registrar 03776 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 23, 2005 Year Benjamin L. Cox /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Keninsula regional Nedical Center If Under 1 Year WICOMICO 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. 1 **□**MM 2 □ F Hours Yrs. Director 262-22-4938 Aug 26, 1920 FLUsual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Evaninar must be notified at 1 Yes 2 No Directo 28a-f s Wicomico Eden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 26519 Walnut Tree Rd. 21822 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 DXYes 2 □ No Navy If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No δ Specify: Black 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit Pages 1 and 2 should be filed within 7;
Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "na any in lury or other traumatic event, the Madic 2006. Elementary/Secondary (0-12) College (1-4or 5+) Cement Finisher 8th Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin L. Cox, Sr. Pearl K. Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Minnie M. Cox/wife 26519 Walnut Tree Rd., Eden, MD 21822 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State * 4 ☐Donation 5 ☐ Other (Specify) Springhill Memory Gardens 1/29/2005 Salisbury, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home 23a. Part . Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due L. (or as a consequence of) **Examiner** Sequentially list conditions, I cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 4 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Thpatient 2 ER/Outpatient 3 DOA il Director: After this od in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No death 2 Accident 6 Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by determined 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number me 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Na 100 PONER m. o. 51. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

363-22-49

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 29, 2005 **Physician** JANUARY 3:45 PM ETHEL LOUISE CAVES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REEDERS MEMORIAL HOME WASHINGTON BOONSBORO 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖾 F Yrs. Director 713**-**12-3569 98 MARCH 1906 NEW YORK Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show r than "natural", or itama 23a or 28a-f shov the Medical Examiner must be notified at 1 M Yes 2 No Directo MARYLAND WASHINGTON **BOONSBORO** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 141 SOUTH MAIN STREET 21713 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ofiled within 72 hours after I Hygiene.

other than "natural", or ita 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 212 No Specify: Specify. <u>م</u> 3 X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 HOMEMAKER OWN HOME permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HENRY WALLACE CRANDALL LENA BLANCHE CLARK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM E. CAVES/SON 1018 ROSEMONT DRIVE, KNOXVILLE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ' 4 □ Donation 5 ☐ Other (Specify) SMITHSBURG CREMATORY 01/31/2005 SMITHSBURG, MARYLAND 21. Signature of Figeral Service Licensee 22. Name and Address of Facility 7606 Old national Pike Paul M. Dean BAST FUNERALHOME Boonsboro, Maryland 23a. Part . Enter the disease of complications that cause shock, or heart failure. List only one cause on each complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chobale /Medical **Examiner** Chiantic. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ng physician and as the burial-transit that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death Records, P.O. 9 Unknown 9 Unknown I Hospital or Attanding Proves.
24 hours after death.
a Funaral Director: After this certificate has been signed by a funaral Director. After this certificate has been signed by a funaral director, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 2□ No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00062223. 31/05. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21740 340 Mill Street, Hagerstown, Maryland Dr. Praveen Bolarum 31. Date filed (Month Aat YSn) 2005 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Amend# 2.Per Phys.PGC 2-1-05 cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day 21, Year Month **Physician** January AGATHA CLUNE $\frac{20}{100}$ 2005 4:00 a.m. /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent Center Crofton
If Under 24 Hrs. Anne Arunde1 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) 6. Sex **Funeral** Deys Months Hours 1 ☐ M 2 🛛 F Yrs 89 Director 215-44-4103 Feb. 5, New York Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours after death with the Merylend nent of Health end Mental Hygiene. Int: If Item 27 is marked other than "natural; or Items 23s or 28s-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23a or 28a-f shot traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Directo Maryland Prince George's Hyattsville 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 6208 41st Avenue 20782 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Status Black, White, etc. 1 ☐ Yes 2 🗓 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher 4 Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peter Cahill Annie Hayes 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) item 27 other to Dennis Clune - Son 4006 Quintana St., Hyattsville, MD 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ò Depentment of Important: If 4 ☐ Donation 5 ☐ Other (Specify) injury Gate of Heaven Cemetery 1/24/05 Silver Spring, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** fmmediate Cause (Final disease or condition resulting in death) /Medical Pneumonia Examiner Due to (or as a consequence of): Examine use es the buriel-trensit or Attending Physician: The law requires thet the deeth certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 📉 Unknown 1 ☐ Yes 2 ☐ No Cerebrovascular Disease 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was en autopsy performed? 2 🔯 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA edicai Certification: To 1 Yes 2 No filled in by the funeral 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury Injury at Work? 28c. 28d. Describe how injury occurred 5 Pending investigation 1 Natural s efter deeth. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) lace D31136 January 21, 2005 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 9005 Kilbridge Road, Baltimore, Maryland 21236 Brian C. Wallace, MD. 31. Date filed (Month, Dey,) 32. Registrer's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death z 25,2005 Physician Allan Page Clagett, Jr. January 1:00AM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Charles County Nursing Rehab Center La Plata Charles 8. Date of Birth Month, Day, Year) March 27, 1914 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 215-10-7549 1 1 M 2 F 90 Maryland Director Usual Residence of Decedent 10a, Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits I hygiene. other than "natural", or tems 23s or 28s-f show vent, the Medical Examiner must be notified at 1 Ves 2 No Directo MD Charles La Plata 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 201 East Hawthorne Drive 20646 USA death by Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1√2 Yes 2 □ No If Yes, Give altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Sales Representative Food lith end Mentel Hygier 27 is marked other til r traumatic event, the 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 end 2 should be nent of Health end Mentel Allan Page Clagett, Sr. Cora Hawkins 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) itam 27 is Laurie Taylor/Granddaughter 201 East Hawthorne Dr. La Plata, MD 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 6 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Rest Cemetery 1/29/05 La Plata, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2AREHARTSECHULS FUNERAL HOME, P.A. M00945 P.O. BOX 567, LA PLATA, MD. 20646 4hu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest physician s the buriel of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) ettending p use isigned by the et id be deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 25101 Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? DISURDER 3,42 E 1 Yes 2 NO 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: After this certifice completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or **Destifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end add ress of person who completed cause of deeth (Item 23e) (Type, Print) 102 PAULMELLON CT SHVIN

DHMH 16 Rev 6/95

State

Registrar

2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month John Francis Clark 10:00 P™ 22, January 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year May 30, 1 9. Birthplace (State or Foreign **Funeral** Months 1 2 M 2 ☐ F 86 Director 578-09-0868 Yrs. **1**918 Washington, DC Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examina maintee notified at Maryland Anne Arundel Annapolis Directo 1 Yes 2/2No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3732 Ramsgate Drive 21403 U.S.A. Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Tyes 2 No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Corporation Taxes Federal Government 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 Is marked oth any linjury or other traumatic even <u>once.</u> Francis D. Clark Nettie Roberts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3732 Ramsgate Drive Annapolis, Maryland 21403 Jessie Clark/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Gardens 1/26/2005 Annapolis, MD ¹ 4 □ Donation 5 □ Other (Specify) Fune al Aervice Licensee 21. Signature 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Respiratory Failure **Physician** disease or condition resulting in death) 2 hours /Medical Due to (or as a consequence of): Examiner 18 days Cholestatic Jaundice Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner this certificate has been signed by the attending physician and ral director, page 2 should be deteched for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Peritonitis 18 days resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Perforated Duodenal Ulcer 18 days Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Sick Sinus Syndrome 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Pacemaker 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? End Stage Renal Disease 2 🗆 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo ဥ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred : After 5 Pending investigation 1 XNatural death. М 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital c within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 08314 January 23, 2005 cu rouces 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Samaras 116 Defense Highway, Suite 400 Annapolis, MD 21401 31. Date filed (Mark) Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Jan. 23, 2005 Physician John A. Fissel 2:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery National Lutheran Home Rockville 5. Social Security Number 207-07-6460 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Dec. 15, 1910

9. Birthplace (State or Foreign Country)
Pennsylvania 6. Sex **Funeral** Hours Months Days 1**Д**М 2□ F 94 **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov the Medical Examiner must be notified at Director Md. Montgomery Rockville 1X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number -0 9701- Veirs Drive 20850 USA Items 23a Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. nned Folces: 1 □ Yes 2 □ No If Yes, Give Year or Dat**U**:nknown 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Not Available 12 ulth and Mental Hygid 27 Is marked other r traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H lent: If item 27 Is marked off Be Daniel S. Fissel Bertha Stambaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs.Kristina E.Hughes-Executor-9701-Veirs Dr., Rockville, Md. 20850 other 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 6 X Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Mem.Gar. 1/31/2005 Harrisburg, Pa. sertent: I crtent: I r injury o * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Hysong Co., Inc.
6510-16th St., NW., Wash., DC permit.
Dep. rdr
Importe
any inj 21. Signature of Funeral Service Licensee that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, a gri hach line. 23a. Part1. Enter the disease, or comshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Lista of Lista) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): of Vital Records, P.O. Box 68760 Be Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 21-No 1 Tes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division 5 Pending investigation 1 Natural nours after death. Inerel Director: Aft filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number enel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr.Charles W. Karesh- 9701-Veirs Dr., Rockville, Md. 20850 31. Dal AIN (2006. 0210 1951) 32. Registrar's Sign State Registrar

			1 - For State Registrar	State of M	arylan		artment rtificate			nd Me	_	giene Reg. No.	005	03	782
	Dhysisi		1. Decedent's Name (First, Middle, Las	t)						1	2. Date of De Month	ath Day	Yea		me of Death
	Physici /Medic		KEVIN EUGENE								JAN.	21	200	5 2:	55 P ^M
	Examin	er	4a. Facility Name (If not institution, give				4b. City, To			f Death			County of De		
_			College View 5. Social Security Number 6. So			er ast birthday)	FREI		LCK If Under 2	24 Hrs.	8. Date of Bir		REDER		tato os Fomias
	Funeral Director			M 2□F	73_	Yrs.		Days	Hours	Min.	(Month, Da AN 20	y, Year)	32	MD	tate or Foreign
	yland Iow	i	10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Insi	ide City Limits
	a-f st	tor	MD FREDER	ICK	F	REDEF	RICK							1 🗟	Yes 2 □ No
	or 28	Funeral Director	10e. Street and Number				10f. Zip C	Code				10g. Citiz	en of What	Country?	
	ath w	rail	700 TOLL HOUS					1701				US			
	ltems	nue	11. Mariifal Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Armed Forces' 1 ☐ Yes 2 ☑	?/	S. 13.	Was Decede If Yes, specif	nt of His ly Cuban	panic Orig , Mexican	jin? (Spec , Puerto R	ofy Yes or No lican, etc.))- 1	 Race - Ar Black, WI 		an,
36	irs aft	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	No No	Specify:				Specify: W	HITE	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. id other than "natural", or items 23a or 28a-f show event, the Medical Examinar multite. Indifficit all	ted	15. Decedent's Ed			16a. Dece	dent's Usual	Occupat	tion	-fdd-		16b. Kir	nd of Busines	ss/Industry	
215	thin 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of work DO NOT use	retired)	ırıng most	or working	g				
2	led wi lygien her th	Con	10			LAND	SCAPI						IDSCA:	PING	
and	ntal H ed otl	To Be	17. Father's Name (First, Middle, Last) HERMAN FITZWA	ਰਜਾ							(First, Middle		Sumame)		
ž	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examinar number outlifted at	ို	19a. Informant's Name/Relationship (10h Mailie	na Address /	Street av			CULL Route Numb		Town State	Zin Codol	
Maryland	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marke any injury or other traumatic: once.			ISTER							D., B	•		208	111
	s 1 ar f Hea item other		20a. Met/lod of Disposition			lace of Dispo	sition (Name	e of		1/25			cation - City		
Baltimore,	Pages nent of I int: If its iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		9	DS PR	-		" HURO	1/25 CH	/05	BOZ	DS, I	MD	
alti	permit. Departmitemporta		21. Signature of Tune Stryice Licen	500		22	2. Name and	Address	of Facility	у					
<u> </u>	88 = 8		23a. Part 1. Enter the disease, or com	1		H P	ILTO	V FU BOX	JNERA 86	AL H	OME NESVI	I.I.E.	MD	2083	8
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or com, sock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. A () Due to (or as	TE s a consequ	PY (uence of):	Elok					rrest,		Interv	ximate ail Between and Death DAYS
8760,	death certificate be executed e attending physician and d for use as the burial-transit	edicai Examine	if any, leading to immediate cause. Entire Unidentlylling Cause (Disease or injury that initiated events resulting in death) Last	C											
.O. Box 6		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ □ Unknown								2	23d. Date of delivery Month Day Year		Year	
rds, P	w requires that the sbeen signed by the should be detached	by										contribute to the cause of death?			
Vital Record	e law has b	ompieted									24a. Was auto perfo		24b. Were prior to death	o completion?	dings available n of cause of
ital	i cian: Th certificate ector, pag	Be C	25. Was case referred to medical						26. Place	of Death	(Check only			20 20 11	
of V	S S	To	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpat	ient 2 🗆	ER/Outpatier			4 9 NU	rsing Hom	ne 5□Resi	dence 6	Other (S	oecify)	
ם			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, D	jury ay Year)	28b. Time o Injury		lc. Injury Work			8d. Describe	how injury	occurred /		
Division	or Atten ifter deal Director: in by the	ertification;	2 Accident investigation 2 Accident investigation 3 Suicide 6 Could not be determined building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural in City or Town, State)									Ru <i>ral R</i> oute	Number,		
	4 4 4 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	edical C	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exar	ysician: To the bes niner: On the basis and manners	of examina	wledge, deat tion and/or in	h occurred a	it the time in my opi	e, date an inion, deal	d place, ar th occurre	nd due to the	cause(s) date and	and manner place, and d	as stated. lue to the ca	use(s)
	To the within 2.	Me	29b. Signature and title of certifier				29c.	License	number				e signed (Mo		ear)
)			1	Tim			D	-31	912			1/	24/0	35	
	(\mathcal{L})		30. Name and address of person who	completed cause of			Print)							^	
				ND-15			20107	PI	us,	ME	DEM	w,	MD	9170	12
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	2005 32. Rollis	trar's Signa	iture	Acces!	A							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla		artment of H			ene 0	05	03784	
	Physici		Decedent's Name (First, Middle, Last) Frances Gilliam					2. Date of Death Month January	1	2005	3. Time of Death 5:10 P M	
	/Medio Examin		4a. Facility Name (If not institution, give st. Holy Cross Hos	reet and number)		Silv	Location of Death	g	4c. County	of Death	gomery	
	Funeral Director		220 30 0133		rs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Apr. 15	Year) 1935	9. Birthp Coun Sout	lace (State or Foreign try) h Carolina	
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgo		City, Town or Lo		ckville			1	10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	with the 3a or 286	i Direc	10e. Street and Number 709 Monroe St., #102 20850						g. Citizen of V	What Coun	•	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. Ite Medical Evaninal must be notified at anone.	by Funeral Director		2. Was Decedent Ever in Armed Forces? 1			las Decedent of Hispanic Origin? (Specify Yes or No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes X No Specify:					
Baltimore, Maryland 21215-0036	s within 72 hou piene r than "nature the Medicul E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th 16a. Decedent's Usual Occupation (Give kind of work done during most of work done) (Give kind of work done) (Give kind of work done) (Bive kind of work done)						16b. Kind of B	usiness/Ind		
land	uld be filed fental Hyg rked othe	To Be C	17. Father's Name (First, Middle, Last) Pink Rob	bs			18. Mother's Nan	Lois		ne)		
Mary	nd 2 shou Ith and M 27 is mai		19a. Informant's Name/Relationship (Type JoAnn Johnson - D	•	1	ng Address (Street:						
imore,	Pages 1 arment of Hea ant: If item ury or othe		20a. Method of Disposition 1 X Burial 2 Cremation 3 Re '4 Donation 5 Other (Specify)	20b	cemetery, crei	et Cemete	е)		Wash			
Balt	permit. Depart Import any Inj		21. Signalure of Funeral Service Lidense	out III	22	2. Name and Addres		tewart F			20019	
8760,	Physician / Medical Examiner physician and the prival-transit	dicai Examiner	23a. Palt Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Inderiving Cause (Disease or injury that initiated events resulting in death) Last d.	Anoxic Due to (or as a cons Chroni Due to (or as a cons	Enceph sequence of): Apnea sequence of): c Obstu	alopathy			St,		Approximate Interval Between Onset and Death	
.O. Box 68	death certifi e attending I od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of prec 1 Live birth 2 F 4 Pregnant at time o	etal death 3	Ectopic pregnancy Other (specify)				te of delive	ery Day Year	
rds, P.	es be	by	Part II. Other significant conditions cont Hyperte		23e. Did tobacco use contribute to the cause of death. 1 X Yes 2 No 3 Probably 4 Unknown							
Vital Record	e law has b	ompieted	Diabetes Type II 24a. Was an autopsy performed? death?									
f Vital	ysician: is certifica director, j	To Be C	25. Was case referred to medical examiner?	ovascular Ac		nt 3□ DOA Oth		th Check onl one	,		2 X No	
Division of	Attending Ph r death. ector: After th by the funeral	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injun Worl	/ at		me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
DİVİ	in the		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe	ecify)			28f. Location (Str City or Town	, State)			
	Hos Fur fely	edicai	29a. Certifier 1 X Certifying Physic (Check only 2 Medical Examinone)	er: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and ma ite and place,	anner as st and due to	ated. the cause(s)	
)	To the To the Complete	Σ	29b. Signature and title/of certifier	AMIM		29c. License	D-59284		d. Date signe			
	The same			npleted cause of death (I		Print) orest Gle	en Rd., S	ilver Sp	ring, N	1D 20	0910	
	Sta Regist		JAN 2 6 2005	32. Registrar's Sig								

03785

1 - For State Registrar

Dharatata		Decedent's Nam	ne (First, Middle,	Last)							2. Date of De Month	eath Day		1001	3. Time of Death
Physicia /Medic		Mary Go:	ffigan								Janua		1 200	ear_	115JA N
Examin		4a. Facility Name ('If not institution,	give street and nu	ımbər)			4b. City, Town, o	r Location	of Death		1	County of	Death	
4.7.0.	•	Princ	= (e	ries h	105%	cital		chev	211				rince		٦٠ ح
Funeral		5. Social Security !		6. Sex	- 4	(In yrs. last bin	thday)	If Under 1 Year	If Under		8. Date of Bi	rth			lace (State or Foreig
Director		113-28-6	4/43	1 ☐ M 2 🖸 F		70	Yrs.	Months Days	Hours	Min.	(Month, D	ay, Year)		Coun	gomery, Al
		Usual Residence			L	70			-		верс.	12,1	734 11	OHC	50mery, Al
and tand		10a. State	10b. County			10c. City, Town	n or Loca	ation						1	0d. Inside City Limits
f sh	0	MD	Prince	Georges		Riverda	ale								1⊠Yes 2 No
the Maryland 28a-f show	ect	10e. Street and Nu						104 Tin Code				10- 04		-10-	
with or	늅							10f. Zip Code				iog. Cit	izen of Wh	at Coun	try?
death with the Maryland ims 23a or 28a-1 show	Funeral Director	6824 Furi	nan Park				,	20737					USA		
r de	au e	11. Marital Status		12. Was Dec		ver in U.S.	13. W	as Decedent of H Yes, specify Cuba	lispanic Or an, Mexica	igin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Black.	Americ White,	
or Ite			ried 2 Marrie	d 1 □Yes If Yes, Gi	2 <u>y</u> ENo ive)	1	☐Yes 2☑No					Specify:		
urel',	d by	3 ∟ Widowed	4 Divorced	Year or E	Dates:							İ	opecity.	Blac	k
filed within 72 hours Hygiene. kther then "neturel", snt, the Mcdral Exa	Completed	(Spe	15. Decedent's	Education grade completed))	16a.	Decede	nt's Usual Occup	ation	st of work	ina	16b. K	ind of Busi	ness/Inc	lustry
thin an.	npi	Elementary/Sec		College (-)	life. Do	ind of work done O NOT use retired	d)		3				
gien grth arth	Ö	12th				Air	line	Reserv	ation	ist		Pri	vate		
e file oth oth	Be (17. Father's Name	(First, Middle, L.	ast)					18. Moth	er's Nam	e (First, Middle	e, Maiden	Sumame)		
ic e	ToE	Booker T	. Andrew	vs.					Fra	nces	Byrd				
shou nd M mar imat	-	19a. Informant's N	lame/Relationshi	p (Type, Print)		19b	. Mailing	Address (Street				ber. City o	r Town. St	ate. Zip	Code)
d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2				an/Daught	er			frey Al							
1 an Heal em 2 ther		20a. Method of Dis						tion (Name of	1		Date		ocation - C		
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other treumatic event, the Modes.		1 Burial 2	Cremation :	3 □Removal from	State	cemeter	ry, crema	atory or other place	I					•	
Pa Imen jury		° 4 □ Donation	5 Other (Spi	ecify)		Riverd	ale	Cremato	ry J	an.2	6,2005	Rive	rdale	e, M	D
ppart port y in		21. Signature of F	uneral Service L	icensee	1	X.	22.	Name and Addre	ss of Facili	ity Joh	nson &	Jenk	ins I	une	ral Home
89789			ma	- Ch C	Ser	9 m	716	Kenned	y St.	NW	Washing	cton.			
		23a. Part1. Enter	the disease, or o	omplications the	cau ed t	the deal Dor	not enter	the mode of dyir	ng, such as	cardiac	or respiratory	arrest,			Approximate
Dharisin		Immediate Cause		rily of the Cause of	94 11116		11								Interval Between Onset and Death
Physician /Medical		disease or conditi resulting in death	on	_ a DC	460	lural	17	emato	ma						
Examiner			1	Due to	(or as a	consequence	of):								
	_	Sequentially list c	onditions,	b	all										
D :=	ine	cause. Enter Und	erhving	Due to	(or as a	consequence	ot):								
acute ind trans	Examiner	Cause (Disease of that initiated even resulting in death)	ts	с											
be executed sician and burial-transit		resulting in death)	Lasi	Due to	(or as a	consequence	of):								
death certificate be executed e attending physician and d for use as the burial-transi	cian/Medicai		'	d											
tifica ig ph as th	ed														
eath certific attending pl	N/	IF FEMALE: 23b. Was decede	nt pregnant	23c. If yes, ou	tcome o	pregnancy							23d. Date	of delive	ry
death atte	cia	in the past 1:	2 months?			Fetal death ime of death		Ectopic pregnancy Other (specify)	У				Month	1	Day Year
	ıys	9 Unknow		9□ Unkr	nown										
The law requires that the de ate has been signed by the a bage 2 should be delached f	by Phys	Part II. Other sign	ificant condition	s contributing to	death but	t not resulting in	n the uno	derlying cause giv	en in Part	l.	23e. Did	tobacco i	use contrib	ute to th	e cause of death?
sign d be						_		, ,			10	Yes 2	No 3	☐ Prob	abiy 4 ⊟Unknow
w require been si should I	Completed	-													
ne law has b	ğ	<u> </u>									24a. Wa	s an opsy	24b. We	ere autopor to con	psy findings available npletion of cause of
	Ö										perl 1 ☐ Yes	formed? 2 No		ath?] Yes	2 No
Attending Physicien: The la ir death. ector; Afler this certificate has by the funeral director, page 2	e e	25. Was case refe	erred to medical						26. Plac	e of Deal	h (Check only				
ysic is ce direc	o B	examiners 1-Yes 2] No	Hospital: 1	Inpatien	nt 2 ER/Ou	Itpatient	3∏ DOA Oth	er: 4 🗆 N	ursina Ho	me 5□Res	idence	6 □Other	(Specify	()
Ph arth aral	T:U	27. Manner of Dea	ath	28a. Date		28b.	Time of	28c. Injur	ry at		28d. Describe				
th. : After funer	i i	1 ☐ Natural 2 ☐ Accident	5 Pending investigation		nth, Day		160	OM 1□	rk? ∣Yes 2-1 <u>—</u>	No	home	1, 4	ead	7-75	iciny
or Attending Phatter death. Director: After the	lica	3 Suicide	6 ☐ Could no	ot be	-		arm, stre	et, factory, office			28f. Location	(Street ar	d Number	or Rura	/ Route Number.
in Dir	Certification:	4 🗍 Homicide	determin	build	ding, etc.	(Specify)	lom				City or To	own, State	168a	4 F	congan
pital ours eral		20a Cartina	. □ Contituiu	Dharistan Tari							ANEW				MARY lARNO
To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fi	edicai	29a. Certifier (Check only	2 Medical E	Physician: To the taxaminer: On the t	basis of	examination an	e, death d/or inve	occurred at the tile estigation, in my o	me, date ai opinion, de:	nd place, ath occur	and due to the red at the time	e cause(s) , date and) and manr d place, an	ner as st d due to	ated. the cause(s)
the the	Med	one)	1.01	and mar	nner stat	ed.		00: 11:				001.0			5 7 1
T So	-	29b. Signature an	a title of certifier	1 11		_		29c. Licens				29d. Da	te signed (Month,	Day, Year)
(10)		Se	Loader	1 plu	86	v 90		ito	053	82.		JAN	inpry	20	t, 2005
(1%)		30. Name and add	dress of person w	no completed cau	ise of de	ath (Item 23a)	(Туре, Р	rint)			7				/
Je		Salvan	Lev Sul	veter	30	01 1tos	di	tal Dry	re,	CL	everle	· n	140	119	rd
Sta	te	31. Date filed (Mg	nth Day Year)	32.		r's Signature					01	/			
		IANI 4 C	<i>Z</i>	Madra .	W.	Sec. of									

				Please	Type or Pri	int in Bla	ack In	delible Ink	. Ensure A	II Copies A	Are Legibl	e.		
				1_ For State	State of M	faryland.	•	artment of H	Health and N		200	5 0270		
				Registrar	actl		Ce	runcate of	Deain		g. N6 U U	0 00/0		
		Physic	ian	Decedent's Name (First, Middle, Last)						2. Date of Death Month	Day Y	3. Time of Death		
4		/Medi		Eileen B. Gray				# 0' T		JANUAR		05 2122		
		Exami	ner	4a. Facility Name (If not institution, gi				4b. City, Town, o	or Location of Death		4c. County of			
				the Memor 5. Social Security Number 6.		SP DTA ge (In yrs. last		If Under 1 Year	If Under 24 Hrs.	TALBOT				
		Funeral Director		218-48-2507	1□M 2∏F	58	Yrs.	Months Days		8. Date of Birth (Month, Day, Oct 25				
		ylend		Usual Residence of Decedent 10a, State 10b, County		10c. City, T	own or Lo	ocation				10d. Inside City Limi		
		permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28e-f show amy Injury or other treumatic event, the Madical Examinar must be notified at sonce.	Director	Maryland Caroli	ne	G	o1dsl					1 X Yes 2 □ N		
		vith to	급	10e. Street and Number	_			10f. Zip Code		10	g. Citizen of Wha	it Country?		
		s 23	ra	212 Old Line Roa				2163			USA			
		ter de Itam	Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Deceden Armed Forces 1 \(\text{Yes} \) 2 \(\text{X} \)	?	13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.		
	Maryland 21215-0036	ours af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1□Yes 2ሺNo	Specify:		Specify:	White		
	5-0	72 h	Completed	15. Decedent's E (Specify only highest g	Education rade completed)	1	6a. Dece	dent's Usual Occup	nation during most of work	ina 1	6b. Kind of Busin	ess/Industry		
Eileen	121	vithin ne. han	mp	Elementary/Secondary (0-12)	College (1-4or	5+)			during most of work d)		_			
Ü	2	iled v lygie her t	ပိ	12 17. Father's Name (First, Middle, Las			sear	nstress			manufac	turing		
-	anc	be feat liber	Be		· ()					e (First, Middle, M	,			
ω	2	d Me nark natio	2	Melvin Benton 19a. Informant's Name/Relationship	(Time Deint)		OF A4-10			LaBerr				
5	Ma	d 2 sl th an 7 is r treur							and Number or Run					
4		1 an Heali em 2		Terry R. Gray/ h	uspand	20b. Place			Road Gol		MD 21636 0c. Location - Cit			
GRAYS	altimore,	ages nt of r: If It		1 XBurial 2 ☐ Cremation 3		7		sition (Name of matory or other place		_				
05	Ē	artme		*4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice	• •	Green		O Cemete: Name and Addre		1 2005 G	reensbor	o, Maryland		
	Ba	Depar Important Ir		21. Signature of the least service close	10		F.	eegle an	d Helfenb Greensbo	ein Fune	ral Home	PA		
		Frysician /Medical Examiner		23a. Part1. Enter the disease, or cor	nplications that cause	d the death. [o not ent	er the mode of dvir	Greens DO	r respiratory arres	1039	Approximate		
				Shock, of heart tailure. List only one cause on each line.										
			1	Immediate Cause (Final disease or condition resulting in death) a. Respirato Fasture Due to (or as a consequence of): A cute pneumonitis										
-				Acute pneumonitis										
			ē	Sequentially list conditions,	U	я а попеворияли			,,,,,					
		uted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	·	,								
	•	be executed siclan and burlat-transit	xa	that initiated events resulting in death) Last	Due to (or as	s a consequenc	ce of):							
	760,	e be sicla	as a		d									
	Box 687	ificate g phy as the	Physician/Medic		0.									
	ŏ	n cert	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy					23d. Date of	delivery		
	m	death e atte	Ca	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a	2 Fetal death at time of death		Ectopic pregnancy Other (specify)	<u> </u>		Month	Day Year		
	P.O.	it the by th tache	hys	9 ☐ Unknown	9□ Unknown									
		The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	by P	Part II. Other significant conditions		but not resultin	g in the u	nderlying cause giv	ren in Part I.	23e. Did toba	cco use contribu	te to the cause of death?		
	Division of Vital Records,	w require been sig	ed	Hypotensi						1 X Yes	2□No 3[Probably 4 Unknow		
	900	has be	Completed	metastat,	c stage	TV no	77-51	nd/cell	Lung	24a. Was an	24b. Wer	e autopsy findings availab		
	Ä	The ate ha	E O		0			Car	rcer	autopsy performe	ad? deat	rto completion of cause of h? Yes 2□ No		
	ita	ien: irtifica	Be	25. Was case referred to medical examiner?					26. Place of Death	(Check only one)	•	100 20110		
	†	nysic nis ce direc	To	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 121 Inpati	ient 2 ER/	Outpatien	t 3□ DOA Oth	er: 4 🗆 Nursing Ho	me 5 Residen	ce 6 Other (Specify)		
	0 U	ng Pf fter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, Da		. Time of		y at	28d. Describe how				
	Sio	endii sath. or: A he fu	atic	2 Accident investigation	on				Yes 2 □ No					
	Ž	or Att ter de lrect	Certification;	3 ☐ Suicide 6 ☐ Could not determined	28e. Place of In building, e	ijury - At home, tc. (Specify)	, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number o State)	r Rural Route Number,		
	Ω	itel o							V					
		To the Hospitel or Attending Physicien: The I within 24 hours efter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best miner: On the basis of and manner s	of examination	dge, death and/or inv	occurred at the ting restigation, in my o	ne, date and place, a pinion, death occurr	and due to the cau ed at the time, dat	se(s) and manne e and place, and	r as stated. due to the cause(s)		
		omple	Me	29b. Signature and title of certifier				29c. Licens	e number	290	1. Date signed (M	fonth, Day, Year)		
		C>F0		> h	Harous	Loura	Jin	0	55484			28-05		
				30. Name and address of person who			,		/			5 05		
				Dr. Laura Jin					gton Stre	et Easto	n, MD 21	601		
		Sta	ite	31. Date filed (Month, Day, Year)		rar's Signature	0							
		Regist	rar	FEB - 1 200	05	. 15	A Time	elf 1						

DHMH 17 Rev 1/2001

			1 _ State	Maryland / Dep	partment of He			2005 03787				
İ	Physicia	an	1. Decedent's Name (First, Middle, Last)	Lidsor)		. Date of Death Month	Day Year COLLE				
	/Medic Examin	al	4a. Facility Name (If not institution, give street and num	(ber)	4b. City, Town, or I	Location of Death	61 3	4c. County of Death				
	Funeral		10/4 2015	7. Age (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. 8	Date of Birth (Month, Day, Ye	ar) 9. Birthplace (State or Foreign Country)				
	Director		Usual Residence of Decedent	80 Yrs.		(2-27-192	24 PHILA, PA.				
	a-f shov	ctor	MARYLAND WICOMICO	10c. City, Town or SALISBI				10d. Inside City Limits 1 X Yes 2 □ No				
	with the a or 28	Director	10e. Street and Number 100 EAST WILLIAM ST.		10f. Zip Code 21801		10g.	Citizen of What Country?				
	death	neral	11. Marital Status 12. Was Dece	dent Ever in U.S. 13	3. Was Decedent of His	panic Origin? (Speci	fy Yes or No-	UNITED STATES 14. Race - American Indian,				
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic avant, I're Medical Evariti at matal terrutified at ODGe.	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, Give Year or Da	2 □ No e	If Yes, specify Cuban 1 ☐ Yes 2 X No	Specify:	carr, etc.)	Black, White, etc. Specify: WHITE				
2-0	"natura	eted	15. Decedent's Education (Specify only highest grade completed)	(Gi	cedent's Usual Occupative kind of work done di	uring most of working	16b	. Kind of Business/Industry				
21215-0036	d within giene. ar than	Completed	Elementary/Secondary (0-12) College (1-	40r 5±)	DO NOT use retired) TUG BOAT CA			MARITIME				
Maryland	id be filed ental Hygi ked othar ic avant, II	To Be (17. Father's Name (First, Middle, Last) VALOROUS HUDSON			18. Mother's Name (First, Middle, Maid ROSELLA					
lary	2 should I and Meni Is marker eumatic	-	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Street a			ty or Town, State, Zip Code)				
	1 and Health am 27 thar tr		DOROTHY J. HUDSON (WIF 20a. Method of Disposition		E. WILLIAM	ST.; SAL		MD 21801 Location - City or Town, State				
Baltimore,	Pages nent of I ant: If its ury or o		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from S 1 ☐ Donation 5 ☐ Other (Specify)	state	rematory or other place RY OF DELMA			ELMAR, DELAWARE				
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service Licensee Richard T. Water	M00 792	22. Name and Address WATSON FUN MILLSRORO	IERAL HOME	, INC. 2	11 WASHINGTON ST.				
1	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death.									
			Immediate Cause (Final disease or condition resulting in death) a. Metastatle Lun Conclusion Due to (or as a consequence of):									
	Examiner		Sequentially list conditions, b.	, as a consequence on,	0							
	ted nsit	Examiner	if any, leading to immediate Due to (cause. Enter Underlying Cause (Disease or injury									
90,	the death certificate be executed y the attending physician and tched for use as the burial-transit		that initiated events c resulting in death) Last Due to (d	or as a consequence of):	· · · · · · · · · · · · · · · · · · ·							
68760,	ificate b g physic as the b	edical	d									
Box	leath certific attending p	lan/M	in the past 12 months?		3 □Ectopic pregnancy			23d. Date of delivery Month Day Year				
P.O.	that the de ed by the a detached f	Physiclan/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregna 9 ☐ Unknown 9 ☐ Unkno		5 ☐ Other (specify)			,				
	es pe	þ	Part II. Other significant conditions contributing to de	23e. Did tobac	cco use contribute to the cause of death? 2 \[\text{No} \] 3 \[\text{Probably} \] 4 \[\text{Unknown} \]							
Vital Records,	e law requir has been si je 2 should	Completed					24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of				
al H	(0 0	e Con	25. Was case referred to medical			00 Di	performed					
f Vii	80 W T	To Be	examiner?	neatient 2 ER/Outpat	Otho	26. Place of Death (r: 4 □ Nursing Home		e 6 ☐Other (Specify)				
on of	ing After une		Terratural S I rending	of Injury h, Day Year) 28b. Time Injury	y Work	at 28 ? ′es 2 □ No	d. Describe how i	njury occurred				
Division	tan leal tor: the	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place buildir	of Injury - At home, farm, ng, etc. (Specify)			f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)				
۵	Hospital or 4 hours afte Funaral Dire tely filled in b					o data and place are						
	To the Hospitel or At within 24 hours after or To the Funarel Direct completely filled in by	edical		asis of examination and/or	r investigation, in my op	inion, death occurred	at the time, date	e(s) and manner as stated. and place, and due to the cause(s)				
	with To t	Z	29b. Signature and title of certifier		29c. License	number 96278		Date signed (Month, Day, Year)				
,	6 mg		30. Name and address of person who completed cause	e of death (Item 23a) (Tyr		/5	673					
			DAVID COWALL UN PUL 31. Date filed (Month, Day, Year) 32. B	Dx /733 igistrar's Signature	Salish	MI) 1	1861				
	Sta Regist			seve H.	Sporte	<i>)</i> '						

			1- State of Maryland / Department / Department / Department / Department / Department / Departme	artment of Health and Mentartificate of Death	al Hygiene 005	03788								
I	Physicia /Medic Examin	al,	1. Decedent's Name (First, Middle, Last) MACTER CERVY HOVIS & 4a. Facility Name (If not institution, give street and number)	M	ate of Death onth Day Year 1900 - 190	3. Time of Death POS 2:19 M								
	, Funeral Director		UMSH / WUTO'S CRUMTY / HSPM7. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 182–32–4740 12	HUNGUNI VUUN If Under 1 Year If Under 24 Hrs. 8. Day Months Days Hours Min. Mark	te of Birth lonth, Day, Year) 9. Birth	MARUN hplace (State or Foreign hnsylvania								
	filed within 72 hours after death with the Maryland Yayana. Ither than "natural", or Itams 23a or 28a-f show int, the Medical Exar, it ar mail be redified at	Director	10a. State 10b. County 10c. City, Town or Location Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Cou											
-0036	hours after death tural', or Itams 2:	ed by Funeral	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	es or No- etc.) 14. Race - Ame Black, Whit Specify: Wh	oncan Indian, e, etc. ite									
d 21215-0036	should be filad within 72 h nd Mantal Hygiene. marked other than "natu imatic event, the Medical	Be Completed	(Specify only highest grade completed) (Give life.	Ident's Usual Occupation skind of work done during most of working DO NOT use retired) Ssembler 18. Mother's Name (First	Truck Mfg., Middle, Maiden Sumame)	,								
, Maryland	nd 2 should lith and Man 27 Is marke r traumatic	To E	Edith Ann Hovis (Wife) 1303	Evelyn A ing Address (Street and Number or Rural Rout 5 Little Antietam Roa	te Number, City or Town, State, 2									
Baltimore,	permit. Pages 1 ar Dapartment of Hea Important: If itam any Injury or othe		*4 Donation 5 Other (Specify)	en Cemetery Jan 29,	20c. Location - City or 05 Hagerstown as A. Fiery Fu	n Maryland								
	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a											
760,	ate be exacuted xx whysician and hysician and the burial-transit	sal Examiner	Sequentially list conditions, if any, isading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
P.O. Box 68	The law requires that the death certificate be exacuted the seen signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physiclan/Medlcal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown 1 2 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown 1 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 4 Pregnant at time of d	23d. Date of del Month	23d. Date of delivery Month Day Year									
Records, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the conditions of the significant conditions contributing to death but not resulting in the conditions of the significant conditions.	3e. Did tobacco use contribute to	robably 4 Unknown									
Division of Vital Rec	ysician: The lav is certificate has director, page 2	o Be Completed	25. Was case referred to medical (Check only one)											
	or Attanding Ph ufter death. Diractor: After th in by the funeral	Certification; To	1 Yes 2 No	5 ☐ Residence 6 ☐ Other (Spe Describe how injury occurred Docation (Street and Number or Reitry or Town, State)										
	To the Hospital within 24 hours a To the Funaral t completely filled	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Sig. tur. and Title of certifier	nvestigation, in my opinion, death occurred at t 29c. License number	the time, date and place, and due	h, Day, Year)								
, , ,	4-10		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) Print) Print) Print) Print) Print) Print) Print)	M1 2074L									
	Sta Regista		30. Name and address of person who completed cause of death (Item 23a) (Type DC 4 MSD MD (USD MONTH) (IND MONTH) (pade										

			For State Registrar	State of M	Maryland		artment of H			-	ene 00	5	037	189
			1. Decedent's Name (First, Middle, I	.ast)					2.	Date of Death			3. Time o	f Death
	Physici /Medio		Mildred Virginia	a HULL					a	Month MKLULIE		Year	8:10	AM
	Examir		4a. Facility Name (If not institution, g	ive street and number	r)		4b. City, Town, or	Location of	of Death	0	4c. County o		0	-
			Washington Coun	ty Hospita	1		Hage	rstow	m		Washir	ngto	n	
	Funeral		Social Security Number 6		Age (In yrs. la		If Under 1 Year Months Days	If Under:	24 Hrs. 8. Min.	Date of Birth (Month, Day, Y	(ear)	9. Birthpi	lace (State o	or Foreign
	Director		212-14-7757	1□M 2⊠F	85	Yrs.		110015		ec. 25,	1919		rylano	
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City	. Town or Lo	cation					1/	0d. Inside C	iby Limita
	/anyl	ŏ		nington		,	gerstown					''		2 No
	289-	Director	10e. Street and Number	itiigtoii		na;	10f. Zip Code			100	. Citizen of Wh	nat Cour		
	3a or		1635 Langley Dr	í vo			2174	0		100		SA	try:	
	death Tra 2:	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U.S	S. 13. V			ain? (Specif	v Yes or No-	14. Race		an Indian	
က	or Iter	Ξ	1 ☐ Never Married 2 ☐ Married	Armed Forces			Was Decedent of H f Yes, specify Cuba			án, etc.)		, White,		
030	e since	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates	:		1 ☐ Yes 2 🕅 No	Specify:			Specify:	wh	ite	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or terms 23s or 28e-1 show that the Medical Examinat ritual be redified at	Completed	15. Decedent's (Specify only highest of	Education	1	16a. Deced	tent's Usual Occupa	ation	t of working	16	b. Kind of Bus	iness/Ind	dustry	
21	ithin	npie	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	DO NOT use retired	1)	t or working					
	ed w ygier ygier th	S	12	1		mana	ger				ome cle		ng pro	oducts
pu	be fill ital H id ott	Be	17. Father's Name (First, Middle, La	•					·	First, Middle, Ma				
<u>\</u>	ould Mer Marks Marks	2	Roy Lester Eber				-			Elizab				
Maryland	12 sh h and 7 ts n		19a. Informant's Name/Relationship				g Address (Street a							
	1 and 1ealth em 27 ther t		Terry A. Hull -	SON	20h Pli	_	34 Cool H sition (Name of	OTTOM	/ Kd.,	_				
Baltimore,	in of the		1 ☑ Burial 2 ☐ Cremation 3		e ce	metery, crer	natory or other plac				c. Location - C	•		
Ę	it. Partimer ritant njury		`4 □Donation 5 □Other (Spe		St.	-	s Cemete		1/31/		lear Sp			
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural; or Items 23s or 28e-f show any injury or other treumatic event, the Medical Examinating in that be notified at anone.		21. Signature of Funeral Service Lig	61900	10 111	(1/	Name and Addres		PIL.	NNICH F				,
			23a. Part1. Enter the disease, or	molications that caus	ed the death		15 E. Wil					1d. 2	Approximat	10
. 6			shock, or heart failure. List on Immediate Cause (Final	ly one cause on each	line.	A	or the mode of dyni	g, 50001 45	our draw or re	ospilatory arres	.,		Interval Bet Onset and	tween
	Physician /Medical		disease or condition resulting in death)	a. Denere	- to	elus						- 4	4-50.	447 -
В	Examiner			Due to (or a	is a consequ	ence of):	D	-					11-5	1\400
	37 - 37	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	ıs a grisequ	ence of):	Infelle	m		1.4		-4-	7) [DAYS.
	uted d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	BLAD	DEM.	CAN	VCFN						Yuna	1 -
o,	exec en an rial-tr	Exa	resulting in death) Last	Due to (or a	is a consequ	ence of):				-		1	1 -411	
8760,	icate be executed physicien and s the burial-transit	dicai		d										
9		Med	IF FEMALE:		-	(i)					т -	<u> </u>		
Вох	death certific attending p	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	e of pregnar		Ectopic pregnancy				23d. Date		. 1	
.o.	s that the death ned by the atter detached for u	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		ath 5	Other (specify)				Mont	ก	Day '	Year
Ρ.	hat the deby	F.	Part II. Other significant conditions	contribution to death	but not rocu	lting in the w	rdorhina couce av	na ia Dari I		22a Did taba				da cab 2
ds,	9 5	1 by	arti, other significant conditions	contributing to death	Dut not 1650	iling in the u	idenying cause give	en in Fan i.			cco use contrib	Proba		Unknown
Ö	w requir been sl shoutd	etec							_		21,110		loly 4	
Records,	sician: The law certificete has b irector, page 2 s	Completed								24a. Was an autopsy performe	24b. We	or to con	osy findings npletion of c	available ause of
a										1□ Yes 25	No 1	Yes	2 No	
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital:			• 3 DOA Othe	0.5		Check only one)				
of	Phy r this ral d	H	1 ☐ Yes 2 🔼 No 27. Manner of Death	1 Lo Inpa		F/Outpatien 28b. Time of	1 JUDON	4 🔲 1901		5 Resident)	
On	nding Ph th. : After thi funeral	tio	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of In (Month, E	day Year)	Injury	Worl	k? Yes 2 ☐t			,,			
Division	l or Attending after death. Director: After In by the fune	fica	3 ☐ Suicide 6 ☐ Could not	259. Place of I	njury - At hor	ne, farm, str	eet, factory, office		28f.	Location (Stre		or Rural	Route Nun	nber,
ā	s after of Dire	Certification:	4 Homicide	building,	etc. (Specify))				City or Town,	State)			
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying	Physician: To the bes	st of my know	vledge, death	occurred at the tim	ne, date an	d place, and	due to the cau	se(s) and man	ner as sta	ated.	
	the H in 24 the F plete	Medicai	one)	eminer: On the basis and manner	of examinati stated.	on and/or in	estigation, in my of	pinion, deat	th occurred a	at the time, date	and place, an	d due to	the cause(s	5)
	To To To To To	≥	29b. Signature and title of certifier				29c. License	number		290	. Date signed ((Month, E	Day, Year)	
			, De	eu/			D D	4656			AN,	97	, 20	05
,	.] #		30. Name and address of person w	o completed cause of	death (Item	23а) (Туре,	Print)	1	j	h. c :			7	
5	H-4		31 Date filed (Hooth Day Yard	(17)/1	1190	IVIT	PETWA 1	WM)) /	MEENST	DWH	MD	1	140.
	Sta Registi		31. Date filed (Month, Day, Year)	2005 32 Regis	strar's Signati	ure	enter!							
	riegisti	-ear		1		-//								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 - For State Ragistrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Holbrook TTIE MAE 23 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Legional Medical Center WICONICO 8. Date of Birth (Month, Day, 08-15-9. Birthplace (State or Foreign Country) Security Number **Funeral** Days Min 1 □ M 2 🕶 🗲 Q4 Yrs. 219-07-7588 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits other traumatic avant, the Modical Examiner must be notified at Princess MD Be Completed by Funeral Director 1 ☐ Yes 2 ☐No tomerst 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 13111 Mc 21853 U.S.A Intyre I cad Itams 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (XNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ö 1 ☐ Yes 2 📉 No Black Specify: 3 XWidowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2121 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) lomestic tamily. trivate Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I A uthur Matilda JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 13111 Mc Intyre Princess Inne, MD 21853 Itam 27 Linda Lee Oliver RO Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages: Department of H Important: If Its any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 01-29-05 Trinity U.N.C.W.C Cometey ^¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Funcial Hemo Althony E. Wald Funcial Hemo 30689 Hampden Are Princess In 21. Signature * Funeral Service Licensee MD 21853 approc Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Polyonery Frysician 30 yrs. Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death. na Funerel Diractor: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hos within 24 ho To the Fun completely f (Check only one) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

560 Riverside On

32. Register's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

JAN 2 6 2005

Reill

31. Date filed (Month, Day, Year)

29c. License number

024986

BIOI Salisbury md.

29d. Date signed (Month, Day, Year)

1/24/05

/Medical	1. Decedent's Name (First, Middle, Hurtlee	en Gaitor Hill	2. [Date of Death Month Day Year nuary 22, 2005	3. Time of Dec 22:17
Examiner	4a. Facility Name (If not institution, Suburban Hospit	al	4b. City, Town, or Location of Death Bethesda	4c. County of Dea Montgome	
Funeral Director	5. Social Security Number 337-16-3526 Usual Residence of Decedent	6. Sex 1 □ M 2 1 5 F 7. Age (In yrs. last bin 81	. Months Days Hours Min. (/		thplace (State or Fo buntry) bama
Mo M	10a. State 10b. County	10c. City, Town	n or Location		10d. Inside City L
Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Exercitive must be notified at once. To Be Completed by Funeral Director	Maryland Montgo	omery Potor	mac		1 ⊠ Yes 2
ner than "natural", or Itema 23a or 28a-f s. It, the Medical Exactinat brust be notified. Completed by Funeral Director	10e. Street and Number		10f. Zip Code	10g. Citizen of What Co	ountry?
23a c	100. Street and Number 11704 Lake Pot	omac Drive	20854	United Sta	tes
and and	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricar	Yes or No- n, etc.) 14. Race - Ame Black, Whit	
Y. T.	1 Never Married 2 Marrie	If Yes, Give	1 ☐ Yes 2 ☒ No Specify:		Black
d b	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:		1 200	
iete	15. Decedent' (Specify only highest	s Education 16a.	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business	/Industry
than In	Elementary/Secondary (0-12)	College (1-4or 5+)	Secretary	Private	
o C ant	17. Father's Name (First, Middle, L	ast)		st, Middle, Maiden Sumame)	
atic even	Coleman Gaitor			MacGruder	
Tan T	19a. Informant's Name/Relationsh	ip (Type, Print)		ute Number, City or Town, State.	Zip Code)
27 is	Willard Hill, J		704 Lake Potomac Dr.; P		854
othe	20a. Method of Disposition	20b. Place of	f Disposition (Name of Date ry, crematory or other place)	20c. Location - City or	Town, State
y or	1 ☑ Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (Sp	3 Linemoval from State Lin		,2005 Birmingham	n, AL
inju	21. Signature of Funeral Service L	n //		Funeral Homes	
any ir	I (wa) :	< m/ / / / / / / / / / / / / / / / / / /	1131 1131	5 Lockwood Driver Spring, MD.	e ₂₀₉₀₄
	23a. Part 1. Enter the disease, or	complications that caused the death. Do r	not enter the mode of dying, such as cardiac or res		Approximate Interval Betw
ician	shock, or heart failure. List of immediate Cause (Final	ATHEROSCLE	CADAN DADAGA	AR DUEASE	Onset and De
dical	disease or condition resulting in death)	Due to (or as a consequence	of):		-VE /NES
niner			ENDENT DASETES M	ELLITU(4 ENES
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	of):	-	
ial-transit	Cause (Disease or injury that initiated events	с			
urial-	resulting in death) Last	Due to (or as a consequence	of):		
physician and s the burial-transit dical Examin	V	d			
use as In/Mec	IF FEMALE:	23c. If yes, outcome of pregnancy			
for use	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of de Month	livery Day Ye
9 5	1 ☐ Yes 2 No 9 ☐ Unknown	9 Unknown	5 Guille (specify)		
<u>ج</u> ا ا		ns contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacco use contribute to	o the cause of de
hed by the attending physicial detached for use as the burn detached for Medical	Part II. Other significant condition			1 Yes 2 No 3 P	١.
be d	Part II. Other significant conditio			1 103 2 110 0 1.	robably 4-dur
be d	Part II. Other significant conditio				
nas been signer ge 2 should be d mpieted by	Part II. Other significant conditio			24a. Was an autopsy performed? 24b. Were all prior to death?	utopsy findings a completion of car
page 2 should be d				24a. Was an autopsy prior to death? 1 Yes 2 No 1 Yes	utopsy findings a completion of ca
certificate has been signer rector, page 2 should be d Be Completed by	25. Was case referred to medical examiner?	Hospital:	26. Place of Death (Ch	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes eck only one)	utopsy findings a completion of ca
this certificate has been signer at director, page 2 should be d	25. Was case referred to medical	I inpatient 219 EP/Ou	26. Place of Death (Ch	24a. Was an autopsy performed? 1 Yes 22 No 1 Yes eck only one) 5 Residence 6 Other (Spe	utopsy findings a completion of ca
After this certificate has been signer funeral director, page 2 should be different or a Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending	28a. Date of Injury (Month, Day Year)	26. Place of Death (Charter: 4 \(\) Nursing Home	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes eck only one)	utopsy findings a completion of ca
After this certificate has been signer funeral director, page 2 should be dilon; To Be Completed by	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n	28a. Date of Injury (Month, Day Year) ation of be 28e. Place of Injury - At home, fa	26. Place of Death (Ch utpatient 3 DOA Other: 4 Nursing Home Time of nlury Work? M 1 Yes 2 No arm, street, factory, office 28f. L	24a. Was an autopsy performed? 1	utopsy findings a completion of car s 2 □ No
After this certificate has been signer funeral director, page 2 should be dilon; To Be Completed by	25. Was case referred to medical examiner? 1 Yes 22 No 27. Manner of Death 1 Matural 5 Pending 2 Accident investig	28a. Date of Injury (Month, Day Year) ation of be	26. Place of Death (Ch utpatient 3 DOA Other: 4 Nursing Home Time of nlury Work? M 1 Yes 2 No arm, street, factory, office 28f. L	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes eck only one) 5 Residence 6 Other (Spectribe how injury occurred	utopsy findings a completion of car s 2 □ No
After this certificate has been signer funeral director, page 2 should be dilon; To Be Completed by	25. Was case referred to medical examiner? 1 Yes	28a. Date of Injury (Month, Day Year) ation of be ned 28e. Place of Injury - At home, fa building, etc. (Specify)	26. Place of Death (Ch utpatient 3 DOA Other: 4 Nursing Home Time of niury Work? M 1 Yes 2 No arm, street, factory, office 28f. L g, death occurred at the time, date and place, and of	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes eck only one) 5 Residence 6 Other (Spe Describe how injury occurred cocation (Street and Number or Richty or Town, State)	utopsy findings are completion of care 2 No No Nority)
Atter this certificate has been signer funeral director, page 2 should be dilon; To Be Completed by	25. Was case referred to medical examiner? 1 Yes	28a. Date of Injury (Month, Day Year) ation of be ned 28e. Place of Injury - At home, fa building, etc. (Specify)	26. Place of Death (Ch utpatient 3 DOA Other: 4 Nursing Home Time of njury at Work? M 1 Yes 2 No arm, street, factory, office 28f. L	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes eck only one) 5 Residence 6 Other (Spe Describe how injury occurred cocation (Street and Number or Richty or Town, State)	utopsy findings as completion of caus 2 No No Nority)
Ariet uns certificate has been signed funeral director, page 2 should be dilon; To Be Completed by	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day Year) ation of be ned 28e. Place of Injury - At home, fa building, etc. (Specify) g Physician: To the best of my knowledge examiner: On the basis of examination an	26. Place of Death (Ch utpatient 3 DOA Other: 4 Nursing Home Time of niury Work? M 1 Yes 2 No arm, street, factory, office 28f. L g, death occurred at the time, date and place, and of	24a. Was an autopsy performed? 1	utopsy findings a completion of ca s 2 No No Notify) ural Route Numb s stated. e to the cause(s)
To the Funeral Director: After this certificate has been signer completely filled in by the funeral director, page 2 should be demonstrated by the funeral director. To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending investig 3 Suicide 6 Could n 4 Homicide determine the content of	28a. Date of Injury (Month, Day Year) ation of be ned 28e. Place of Injury - At home, fa building, etc. (Specify) g Physician: To the best of my knowledge examiner: On the basis of examination an	26. Place of Death (Ch Other: 4 \subseteq Nursing Home Time of Injury at Work? M 1 \subseteq Yes 2 \subseteq No arm, street, factory, office 28f. L e, death occurred at the time, date and place, and odd/or investigation, in my opinion, death occurred at	24a. Was an autopsy performed? 1	utopsy findings as completion of causes 2 No No Notify) ural Route Numb s stated. a to the cause(s)
ye the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be decompletely filled in by the funeral director, page 2 should be demonstrated by Medical Certification; To Be Completed by	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day Year) 28b. Tale 28b. Place of Injury - At home, fa building, etc. (Specify) g Physician: To the best of my knowledge examiner: On the basis of examination an and manner stated.	26. Place of Death (Ch atpatient 3 DOA Other: 4 Nursing Home Time of niury Work? M 1 Yes 2 No arm, street, factory, office 28f. L e, death occurred at the time, date and place, and or dor investigation, in my opinion, death occurred at 29c License number 27c License number	24a. Was an autopsy performed? 1	utopsy findings as completion of caus 2 No No Notify) ural Route Numbers stated. In the cause(s)
To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be decompletely filled in by the funeral director. Medical Certification; To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending investig 3 Suicide 6 Could n determi 29a. Certifier (Check only one) 29b. Signature and title of certifier	28a. Date of Injury (Month, Day Year) ation of be ned 28e. Place of Injury - At home, fa building, etc. (Specify) g Physician: To the best of my knowledge examiner: On the basis of examination an and manner stated.	26. Place of Death (Chartening Home) Time of niury Mark 28d. M 1 Yes 2 No arm, street, factory, office 28f. L and death occurred at the time, date and place, and or didor investigation, in my opinion, death occurred at 129c. License number 29c. License number	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes eck only one) 5 Residence 6 Other (Spender) Describe how injury occurred City or Town, State) due to the cause(s) and manner as the time, date and place, and due	utopsy findings are completion of care so 2 No scify) ural Route Numb s stated. e to the cause(s)
n 24 mous arter toward. Per function and the this certificate has been signed betanglighted in by the funeral director, page 2 should be defical Certification; To Be Completed by	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day Year) 28b. Tale 28b. Place of Injury - At home, fa building, etc. (Specify) g Physician: To the best of my knowledge examiner: On the basis of examination an and manner stated.	26. Place of Death (Ch atpatient 3 DOA Other: 4 Nursing Home Time of niury Work? M 1 Yes 2 No arm, street, factory, office 28f. L e, death occurred at the time, date and place, and or dor investigation, in my opinion, death occurred at 29c License number 27c License number	24a. Was an autopsy performed? 1	utopsy findings a completion of case 2 No No Notify) ural Route Numbers stated. So to the cause(s)

			For State Registrar	State of M	1aryland / D		ent of H				giene Reg. No.	005	037	192
	Div. et et		1. Decedent's Name (First, Middle, I	.ast)						Date of Dea Month	ath Day	Year	3. Time o	f Death
	Physici: /Medic		PATRICI	A ANN HERM	ANN					anuary			6:30	A M
	Examin		4a. Facility Name (If not institution, g		-	4b. (City, Town, or	Location of	of Death		4c. C	ounty of Deat	h	
			Carroll County			4) 1511	Westmi					Carrol		
b	Funeral			Sex 1 M 2 F 7. A	age (In yrs. last birt)	rs. Mon		If Under Hours	Min.	Date of Birt	y, Year)	9. Birt	hplace (State o untry) inois	or Foreign
L.	Director		357-22-0275 Usual Residence of Decedent	Λ	75				Ap.	ril 4	, 192	9 111	inois	
	/land		10a. State 10b. County		10c. City, Town	or Location							10d. Inside C	ity Limits
	Mar.	to	Maryland Freder	ick	Fred	rick							1. Yes	2 🗆 No
	or 284	Director	10e. Street and Number			10f	. Zip Code				10g. Citize	n of What Co	untry?	
	th wit		2411 Bear Den R	oad			21	701			U	.S.A.		
	ems	Funeral	11. Marital Status	12. Was Deceder Armed Forces		13. Was D	ecedent of Hi	ispanic Ori	igin? (Specify	Yes or No-	- 14	Race - Ame Black, White		
36	or th	y Fu	1 Never Married 2 Married	1 □ Yes 2X If Yes, Give	No			Specify:		, ,		necify:		
Ö	ural',	d by	3 Widowed 4 Divorced	Year or Dates								W	hite	
7	"nal	Completed	15. Decedent's (Specify only highest		16a.	Give kind o	Usual Occupa f work done c OT use retired	durina mos	t of working		16b. Kind	d of Business/	Industry	
21215-0036	withii ene. than	шc	Elementary/Secondary (0-12)	College (1-4o	Sa Sa		ssocia	,				Hecht	's	
0	filed Hygi other ent, I		17. Father's Name (First, Middle, La	st)				18. Mothe	er's Name (Fi	rst, Middle,	Maiden Si	u <i>m</i> ame)		
an	ould be filed within 72 hours after death with the Maryland Mental Hyglene. arked other than "natural", or flems 23a or 28a-f ehow atic event, the Medical Exantractribal ke inclified at	To Be	Anton C. Tausche	ck				Vict	toria N	Wodnid	ck			
ary	2 9 5 5	-	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Add	ress (Street a	and Numbe	er or Rural Ro	oute Numbe	er, City or T	Town, State, 2	Zip Code)	
Σ	and 2 alth a 27 is	1	Robert Hermann (Husband)	241	1 Bea	r Den.	Road,	, Fred	erick,	, Mar	yland	21701	
ore	ges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f ehow or other traumatic event, the Medical Examinating Laundling at		20a. Method of Disposition 1 Burial 2 Cremation 3	□ Bomoval from Stat	20b. Place of cemeter	Disposition r, crematory	(Name of or other plac	:ө)	Date		20c. Loca	ation - City or	Town, State	
Ĕ	Page nent ant: If ury o		'4 □ Donation 5 □ Other (Spe			burg	Cremat	ory	1/27/05	5 5	Smith	sbur,	Maryla	and
Baltimore, Maryland	permit. Pages 1 and 2 si Department of Health an Important: If item 27 is any injury or other traur any injury or other traur		21. Signature of Funeral Service Li	see		22. Nam ROBER	e and Addres	ss of Facilit	y & sor			HOMES,		
<u> </u>	90 E 29	0 10	Full Ag	X		1201	NORTH	MARKE	ET ST.	FREI	DERIC	K, MD	21701	
П			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that caus ly one cause on each	ed the death. Do r line.	ot enter the	mode of dyin	ig, such as	cardiac or re	spiratory ar	rest,		Approxima Interval Be	twaen
1	Pnysician		Immediate Cause (Final disease or condition	BOW	日次	RF	TASC	M					Onset and	Con-
	/Medical Examiner		resulting in death)	Due to (or a	as a consequence	f):	ANC	+ 17					- Archi	0
н	LXammer	L	Sequentially list conditions,	b. UU A	NAN		74100	Y IC						
	ed sit	line	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dua to (cr a	is a consequence (1).								
	xecul and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or a	as a consequence	f):						-		•
8760,	requires that the death certificate be executed en signed by the attending physician and nould be detached for use as the burial-transit	dical E												
687	ificate g phy as the	edic		u							122			
Вох	eath certific attending p	Z/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		۰۰۰۰					23	d. Date of del	ivery	
	death e atte	Ca	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant	2 ☐ Fetal death at time of death		oic pregnancy or <i>(specify)</i>					Month	Day	Year
P.0	that the de ed by the detached	Physician/Me	9 Unknown	9□ Unknown										
	res that signed b	by P	Part I. Other significant condition			the underly	ing cause give	en in Part I	1.	23e. Did to	obacco use		the cause of	
ord	w require been sig	ted	Minipulan	00000	rough			.		1 🗆 \	Yes 2 🕒	+No 3 □ Pr	obably 4 🗌	Unknown
Records,	law as b	ompleted	My o card	xel C	uerct	1:04				24a. Was		24b. Were au	topsy findings	available
H	Th ate pag	Con	1		l					perfo	rmed?	death? 1 ☐ Yes		
Vital	slclan: Th certificate irector, pag	Be (25. Was case referred to medical examiner?					26. Place	a of Death (C	heck only o	one)			
of \	lys dir	ပို	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpa			DOA Oth	4 LINE				☐Other (Spe	city)	
n C	ing F After unera	on:	27. Mann eath 1 ■ atural 5 ■ Pending			ijury	28c. Injun Worl	k?		. Describe t	now injury	occurred		
Sic	Attending r death. sctor: After by the funer	Icat	2 Accident investigat 3 Suicide 6 Could no	t be 200 Blace of	Injuny - At home, fa	M street fo		Yes 2		Location /	Street and	Number or Pi	ural Route Nun	nhor
Division	etter Direction by	Certification:	4 Homicide determin	ed building,	Injury - At home, fa etc. <i>(Specify)</i>	iii, street, te	ictory, onice		201.	City or Tov		realized of Al	arai noute ivan	11001,
_	To the Hospital or Attending Phwithin 24 hours elter death. To the Funeral Director: After the completely tilled in by the funeral		29a. Certifier 1 Certifying	Physician: To the be	st of my knowledge	death occu	rred at the tin	ne date ar	nd niace, and	due to the	cause(s) a	nd manner as	stated	
	e Hos 24 h e Fur letely	Medical		caminer: On the basis and manner	of examination an	Vor investig	ation, in my o	pinion, dea	ath occurred a	at the time,	date and p	lace, and due	to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier	1/ 0-			29c. Licens	e number			29d. Date	signed (Mont	h, Day, Year)	
			Hours	Rull	M)		1)34	539	18		1-2	24 -	05	
	14		30 Name and address of person w	no completed cause of	f death (Item 23a)	Type, Print)				1 :			10 -	(1)
_			THUIO KEU	ER HU	- 555	SICE	NIEV	5	7 - 4	HOD N	TINS	ier i	W 2	1151
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. B	strar's Signature	Apo	de l'							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 1 P. ANTHONY IORIO 23 2005 10:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 25 Anchor Way Worcester Berlin 5. Social Security Number | If Under 1 Year | If Under 24 Hrs. | | Months Days Hours Min. | 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1**X** M 2□ F 73 Director 028-28-2192 NY 12/6/1931 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location worde | 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f ehov the Medical Examinar must be notified at Director 1 ☐ Yes 2X No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25 Anchor Way 21811 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ð Korea 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Aircraft Corp. Pages 1 and 2 should be filed w Iment of Health and Mental Hygie tant: If itam 27 la marked other ti jury or other traumatic event, Li Security Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank lorio Sue Sullo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claire Iorio 25 Anchorway Dr. Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/24705 1 Burial 2XX remation 3 Removal from State injury or 4 Donation Cape Henlopen Crematory Other (Specify) Frankford, DE ral Service Licensee 22. Name and Address The Burbage Funeral Home 108 William St. Berlin, MD 23a. Part1. Enter the disease, or comshock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ung Lancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a nonsequence of) Examiner day, leading to inmodit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit that the death certificate be executed Due to (or as a consequence of): the attending physician hed for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No detached for Dav Year 4☐Pregnant at time of death Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed 2 No Hospital or Attending Physician: 44 hours after death. Funeral Diractor: After this certifice Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗀 Yes 2 No. 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and fittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) BALER 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) C.H.5+1 9733 31. Date filed (Month, Day, Year)

JAN 2 egistrar's Signature State 5 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene) 03794 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** LORETTA CECILIA KELLY 2005 2040 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year 9/30/1927 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 20 F 77 Director 125-20-6084 NY Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. em 27 is marked other than "natural", or Itams 23a or 28a-1 ehow 10d. Inside City Limits the Medical Examiner must be notified at Director MD Worcester Ocean City Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 735 Bradley RD Apt. 504 Be Completed by Funeral 21842 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Director 12 Travel Agency or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Dennis Kelly Alice Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2
Department of Health au
Important: If item 27 is
eny injury or other trau Theresa Carlin 21 Revere RD Ardsley, NY 10502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/24905 1 ☐ Burial 2 XCremation 3 ☐ Removal from State *4 Donation 5 Other (Specify)

21. Smatter of Sun al Service Licensee Cape Heniopen Crematory Frankford, DE 22. Name and Address of Facility The Burbage Funeral Home - usbale 108 William St. Berlin, MD 23a. Pert1. Exercite disease, or complications if at caused the death. Do not enter the mode of a ling, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of neach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ector, page 2 autopsy performed? Yes 252 No 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Planatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident investigation 1 Yes 2 No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) wame and address of person who completed cause of death (Item 23a) (Type, Print) Sichol gistrar's Signature State Registrar

25.20-608

			For State of Maryland / State Registrar	Department of Health and Me Certificate of Death		11115 113/95
)	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last)	onnol	2. Date of Death Month Day anuary 23 4c.	3. Time of Death
	Funeral Director	-	Civista Medical Center 5. Social Security Number 577-14-9409 6. Sex 1 M 2 X 7. Age (In yrs. last to 84)	rithday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth July 30,1	Charles 9. Birthplace (State or Foreign Country Germany
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural, or items 23a or 28a-f show or other traumatic event, it a Medical Experimental be nulliked at	Completed by Funeral Director	MD Charles Be1 10e. Street and Number 8850 Redbay Run 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes. Sup No If Yes. Give N Year or Dates:	wn or Location Alton 10f. Zip Code 20611 13. Was Decedent of Hispanic Origin? (Specify Secretary Specify Cuban, Mexican, Puerto Right Specify: a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Payroll Clerk	10g. Citiz	10d. Inside City Limits 1
Baltimore, Maryland	permit. Pages 1 and 2 should be file Department of Hearth and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, ODGs.	To Be C	William Koennel/Son 20a. Method of Disposition **El Burial 2	Margare 850 Redbay Run, Bed of Disposition (Name of ery, crematory or other place) r Hill Cemetery1/28 22. Name and Address of Facility AREHART-ECHOLS	1 Alton,M 8/05 Sui	Fman Town, State, Zip Code) MD 20611 cation - City or Town, State Ltland, MD HOME, P.A.
8760,	Physician and Image of the pric	dlcal Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or complete the death). Doe to (or as a consequence or complete the death). Doe to (or as a consequence or complete the death). Doe to (or as a consequence or complete the death. Doe to (or as a consequence or complete the death. Doe to (or as a consequence or complete the death. Doe to (or as a consequence or complete the death. Doe to (or as a consequence or complete the death. Doe to (or as a consequence or complete the death. Doe to (or as a consequence or complete the death).	EMOTIC CAMBONA e of):		20646 Approximate Interval Between Onset and Death Office Constitution of the Constitu
O. Box 68	death certii e attending ed for use a	0	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dear 4 Pregnant at time of death 9 Unknown	th 3 □Ectopic pregnancy 5 □ Other (specify)	2	23d. Date of delivery Month Day Year
Records, P.	The law requires that the tee bas been signed by the bage 2 should be detache	Completed by Physician/M	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?
of Vital	ing Physician: After this certifica funeral director,	To Be			24a. Was an autopsy performed? 1 Yes 24 No Check on one e 5 Residence 6	
Division	pitel or Attending ours after death. eral Director: After filled in by the fune	I Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office 28	City or Town, State)	
	To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only only) 2□ Medical Examiner: On the basis of examination a and manner stated. 29b. Signature and title of certifier 30 Name and addr o person who completed cause of death (Item 23a)	and/or investigation, in my opinion, death occurred	d at the time, date and	place, and due to the cause(s) e signed (Month, Day, Year)
44	BIO Sta Regista		31. Date filed (Month, Day, Year) 32. Registrar's Signature	DUD LINE CENTER	Wana	UALY 24, 2505 18, UAD. 20002

CPM 05-00659 Robert Kemp

	1			artment of Health and Me ertificate of Death	ental Hygiei Reg.	000-	00706
	<u>.</u> 9		1. Decedent's Name (First, Middle, Last)		2. Date of Death	2000	3. Time of Death
	Physici /Medic		Robert Henry Kemp		Month January	Day Year 26, 2005	19:38 ™
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Route 313 opposite #13224	Greensboro		Caroline	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign intry)
	Director		217-42-7378 1™ 2□F 65 Yrs.		July 12		yĺand
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or 1	ocation			10d. Inside City Limits
	f sho	6	Maryland Caroline Greensbo				1 X Yes 2 □ No
	28a-	Director	Maryland Caroline Greensbo	10f. Zip Code	100	Citizen of What Cou	into/?
	3a or		13200 Greensboro Road	21639			
	ms 2:	Funeral		Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R		USA 14. Race - Ameri	ican Indian.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23a or 28a-f show minportant: If item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone.	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes 2 ▼ No Specify:	lican, etc.)	Specify: Wh	, etc.
9-0	2 hou	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b	. Kind of Business/Ir	ndustry
215	within 7 ene. than "n	ple	(Specify only highest grade completed) [Giv Giv Iffe.	e kind of work done during most of working DO NOT use retired)	g		•
	od wil	Con	09 labo	rer	fo	od proces	sing
Maryland	12 should be fited within h and Mental Hygiene. 7 is marked other then "traumatic event, the Mec	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	den Sumame)	
yla	Meni Arka arka	ပ	Floyd Kemp, Sr.		e Hunter		
a	2 sho			ing Address (Street and Number or Rural			p Code)
	of Health of Health is litem 27 i			ox 614 Trappe, Mary			
Ore	Pages 1 nent of H ant: If ite ury or otl		I A Burial 2 Cremation 3 Hemoval from State	matory or other place)	200	. Location - City or T	own, State
Baltimore,	permit. Pag Department Important: I any injury o			oro Cemetery 01/31	/2005 Gr	ceensboro,	MD
Bal	permil. Departr Importa		Henre (Fleye	2. Name and Address of Facility leegle and Helfenbe O box 160 Greensbor	in Funer	al Home, 3	PA
т			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	14 juries			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
	Lammer	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	pe lisi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury				
	xecut and II-trar	хап	that initiated events c. resulting in death) Last Due to (or as a consequence of):			-	
8760,	cate be executed physician and ; the burial-transil	E H					
687	ficate p physis the	edical	d				
Вох	nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	renv
Ö.	ires that the death certifi signed by the attending d be detached for use as	by Physician/Me	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year
0	by the	hys	9 ☐ Unknown				
o,	requires that the een signed by th nould be detache	эу Р	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to t	the cause of death?
rd	w require been signal				1 ☐ Yes	2□No 3□Pro	bably 4 Munknown
Records,	> 0 0	Completed			24a. Was an autopsy	24b. Were aut	opsy findings available
H.	Th ate pag	Com			performed	? death?	2□ No
Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death			
of V	88 5	L L	Hospital: 1 Inpatient 2 ER/Outpatient	ont 3 DOA Other: 4 Nursing Home	e 5 🗆 Residence	6 X Other (Speci	y) SCENE
n o			27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Day Year) Injury 1 ☐ Natural 5 ☐ Pending (Month, Day Year)	of 28c, Injury at 28 Work?	Bd. Describe how in	njury occurred	
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation [126/05]	M 1□Yes 2⊅No Ç	ubject s		, lar
Division	or Att	Certification;	4 Homicide determined building, etc. (Specify)	treet, factory, office	Bf. Location (Street City or Town, St	and Number or Run tate) Rou 4 31	al Route Number, 3#13224
	urs at	ပိ		4CF 6	retusburo R	cl, breeusbo	ro IND
	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	th occurred at the time, date and place, an nvestigation, in my opinion, death occurred	nd due to the cause d at the time, date :	e(s) and manner as a and place, and due t	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
			lalines Ali	O.C.M.E.	Ja	nuary 27,	2005
			30. Name and address of person who completed cause of death (Item 23a) (Type				
				Penn Street, Balti	lmore, Ma	ryland 21	201
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1			
	Registi	ar	FEB - 1 2005	603×81			

State of Maryland / Department of Health and Mental Hygiege

DHMH 17 Rev 1/2001

State Registrar

JAN 28 2005

31. Date filed (Month,

were the

32. Registrar's Signature

			1- State of Maryland / Dep	partment of Health and Nertificate of Death		ene2005 03798
			Decedent's Name (First, Middle, Last)		2. Date of Death	
	Physici		Thomas M.		Month January	Day Year 22, 2005 9:30AM M
	/Medio		4a. Facility Name (If not institution, give street and number)	Jeef 4b. City, Town, or Location of Death		4c. County of Death
	LAdillii	CI	1066 Caravan Way	Salisbury		Wicomico
	Funeral		5. Social Security Number 6. Şex 7. Age (In yrs. last birthda	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birthplace (State or Foreign
	Director		221-09-9386 XM 2 F 87 Yrs.	Months Days Hours Min.	(Month, Day, 06-13-1	Year) Country) 917 Delaware
	D		Usual Residence of Decedent			JII JULIANULU
	nylan how		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	a-f s	ç	MD Wicomico Salisbu	ry		1∕2(Yes 2 □ No
	or 28	lre	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
	1h wi	Funeral Director	1066 Caravan Way	21804		USA
	dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Sp tl Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
9	or it	F	1 Never Married 2 Marned 1/2 Yes 2 No	1 ☐ Yes 2X No Specify:	ritioari, otc.)	Specify:
ğ	ural',	d by	③XQ Widowed 4 □ Divorced Year or Dates: WWII			White
21215-0036	72 h	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	ing 1	6b. Kind of Business/Industry
12	withir ene. then	g.	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Itams 23e or 28e-f ehow event, I're Medical Exacilies frinal be indiffed at		12 0 Ge	neral Contractor	e (First, Middle, M	Construction
Maryland	d ol	Be				alderi Sumame)
Ž	should bind Menl	2	Thomas P. Leef 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	Anna M.		
Na	d 2 sho			ling Address (Street and Number or Rur		City of Town, State, Zip Code)
	1 and 1 Health em 27 other tr		Mary Munk/Daughter PO 3 20a. Method of Disposition 20b. Place of Disp	ox 2940, Kodiak, A		9615 0c. Location - City or Town, State
Baltimore,	Pages nent of I int: if its iry or o		1 ☐ Burial 2 Cremation 3 ☐ Removal from State cemetery, cr	ematory or other place)		
Ë	t. Part rtmer rtant njury			y Crematory 01/24		alisbury, Maryland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23e or 28e-f show amy injury or other traumatic event, the Medical Exactinet meat the notified at Once.		221 Signature of Funeral Service Librasee	2. Name and Address of Facility inman Funeral Home	2	
		4	M00295 1	1673 Somerset Ave.	, Prince	ss Anne, MD 21853
ľ	8		33a. Part1. Enter the disbase, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	st, Approximate Interval Between Onset and Death
	Physician	1	Immediate Cause (Final disease or condition resulting in death)	- Haut ta	Mure.	Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	- h i 1	0 1-	2
1 5	-Anglese,	_	Sequentially list conditions. b. Chanic Of	DSTructive Lui	p 1)150	eagl.
	ed isit	lhe	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	102 . Oa . A=	202	many
	and and I-trar	Examiner	that initiated events resulting in death) Last	rescuedor 1/C	cioer	T.
8760,	cate be executed physician and the burial-transit	<u>m</u>	Failwe	To Marive.		I years
87	phys phys the	dical	d. 1 -11 (vco c	1000		
9 ×	The law requires that the death certific lie has been signed by the attending f page 2 should be detached for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			204 Date of delivery
Вох	atten for u	cian	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
P.O.	the d	ysi	1 Yes 2 No 4 Pregrant at time of death 5 9 Unknown	□ Other (specify)		
	that ed by deta	Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
Vital Records,	uires tha signed Id be det	d by	Chisnic renal Insuffi	ciency	1 ☐ Yes	2 No 3 Probably 4 Unknown
200	w requira	ete	Ida dansida (V Assess		04- 146	
Rec	has be 2	Completed	from deficitely trace	4	24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
a	ysician: The Is certificate ha		Staley Post Vent & remains	cycarda on AICI	1 Yes 2	XNo 1 ☐ Yes 2 ☐ No
₹	siciar certii recto	Be	25. Was case referred to medical examiner? Hospital:	Out -	n (Check only one)	
	Phys this rai dii	: To	1 Yes 2 No 1 In Inpatient 2 ER/Outpatie 27. Manner of eath 28a. Date of Injury 28b, Time	THE SELECT THE INTERIOR THE	me 5 Residen 28d. Describe how	ce 6 Other (Specify)
Division of	ding h. After fune	tlon	1 Natural 5 Pending (Month, Day Year) Injury	Work? M 1 □ Yes 2 □ No	ZOG. Describe now	injury occurred
2	deati ctor: / the	ca	3 Suicide 6 Could not be 200 Bloom of Jainey At home form		20f Location /Stra	eet and Number or Rural Route Number.
<u>></u>	after Dire	Certification:	4 Homicide determined building, etc. (Specify)	neet, factory, office	City or Town,	
_	To the Hospital or Attending Physician: which 24 hours after deals To the Funeral Director: After this certifies completely filled in by the funeral director;		29a. Certifier Check cold. Check cold. Check cold. Check cold. Check cold. Check cold. Check cold. Check cold.	th occurred at the time, date and place.	and due to the car	ISA(s) and manner as stated
	24 h Fur e Fur	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or i and manner stated.	rvestigation, in my opinion, death occurr	ed at the time, dat	e and place, and due to the cause(s)
	Fo th within Fo th	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, Day, Year)
	F > F 0		Dens- De- Hound, M.	1 1105284	2 7	an 24, 2005.
		-	30. Name and address of person who completed cause of death (Item 23a) (Type	Print) = 4	111	21)000
			ASMA AL-HAMID, 106 Pine 1	Sinf Rd #12,5	alsbury	,MD 21501.
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registr	-	JAN 2 6 2005 \ Magazine A	1. 4		

			For Stata Registrar	ate of Marylan		rtment of H			giene Reg. No. 0 0 5	03799
	Dhyoisi		1. Decedent's Name (First, Middle, Last)					2. Date of Dea		3. Time of Death
	Physicia /Medic		LLOYD LAVERNE LI					JAN.	23 2005	8:15P M
	Examin	er	4a. Facility Name (If not institution, give stree COUNTRY MEADOWS		LTVING	4b. City, Town, or FREDE		th	4c. County of D	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs	8. Date of Birt	th 9 F	Birthplace (State or Foreign
	Director		332-10-9598 1 ☑ M Usual Residence of Decedent	^{2⊔ F} 85	Yrs.	World's Days	Tiodis Will	MAR 19	1919	Country) I L
	yland now		10a. State 10b. County		y, Town or Loc					10d. Inside City Limits
	e Mar Ba-f st	Director	MD FREDERIC	K	FREDI	ERICK				1 Pres 2 □ No
	with th	Dire	10e. Street and Number 5955 QUINN ORCHA	מא מא		10f. Zip Code 2 1 7 0 4			10g. Citizen of What USA	Country?
	death ms 23	Funeral	11. Marital Status / 12. V	Vas Decedent Ever in U.		Vas Decedent of Hi	spanic Origin? (Specify Yes or No-	- 14. Race - A	merican Indian,
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "neturel", or Items 23a or 28a-f show event. If a Mysical Exsticition in that be multised at	by Fu	1 Never Married 2 Married 1	Armed Forces? Ves 2 No 19 f Yes, Give	43-	Yes, specify Cubar ☐ Yes 2 ☑ No	n, Mexican, Pue Specify:	no Hican, etc.)	Specify: V	
Ö	hours		3 ☐ Widowed 4 ☐ Divorced	rear or Dates: 194		ent's Usual Occupa	ition		16b. Kind of Busine	
215	within 72 ene. then "ne	Completed	(Specify only highest grade con	mpleted) College (1-4or 5+)	(Give I	kind of work done of OO NOT use retired,	uring most of wo	orking		,
121	e filed within al Hygiene. other then '		17. Father's Name (First, Middle, Last)	4	ENG	INEER	10 Mathada Na	ma (First Adiabata	ENGINEER	RING
Maryland 21215-0036	ld be fi ental F ked ot ic ever	To Be	ALEXANDER LINN					ime (<i>First, Middi</i> e, LINDSF	Maiden Sumame) TY	
ary	2 should be and Mental Is marked (eumatic ev	-	19a. Informant's Name/Relationship (Type, i	Print)	19b. Mailin	g Address (Street a	nd Number or R	lural Route Numbe	er, City or Town, State	a, Zip Code)
	5 4 2 G			GREAT NEP			LA., S		CITY, V	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State	emetery, crem	sition (Name of latory or other place CREMAT		25 / 05	FREDERIC	
altin	permit. P Departme Importan eny injur: once.	. 8	21. Signature of Fune S purificensee	IKE	22.	Name and Addres	s of Facility	-	FKEDEKIC	, MD
m	Depa Impo eny ir		Mily			HILTON F			LLE, MD	20838
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call the Council (Fig. 1).	ons that caused the deat ause on each line.	h. Do not ente	er the mode of dying	, such as cardia	ic or respiratory ar	rrest,	Approximate Interval Between Onset and Death
	Fnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq		jelvid	Luks	emia		5 months
	Examiner		Sequentially list conditions b. —	Due to (or as a conseq	derica on:					
-	sit ad	iner	Sequentially list conditions, if any, leading to immediate raise. First Indextying Cause (Disease or injury	Due to (or as a conseq	uence of):					
	sician and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	death certificate be executed e attending physician and id for use as the burial-transi	dical E	d.							
9	ertifica ling ph e as th	Med	IF FEMALE:							
Вох	death certifica attending ph for use as ti	Physician/Me	in the past 12 months?	f yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d	I death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
0.	that the ded by the detached	hysi		∃□Unknown						
ls, P	es be	by	Part II. Other significant conditions contribution	uting to death but not res	ulting in the un	derlying cause give	n in Part I.			to the cause of death?
Ö	v requir been si should	eted	Anemia					1 D Y		Probably 4 Unknown
Vital Records,	e las has ye 2	Completed						24a. Was autop	rmed? prior death	
ita		BeC	25. Was case referred to medical				26. Place of De	1 ☐ Yes eath Check on o		es 2□No
of V	Physiclen: this certific ral director,	၉	examiner? 1 Yes 2 No Hosp	1 Inpatient 2	ER/Outpatient		4 Nursing	Home 5 Resid		pecify)
	Attending F r death: ector: After by the funer.	tlon	27. Manner of Death 2 1 Natural 5 Pending 2 Accident investigation	8a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ? ∕es 2 ⊡No	28d. Describe h	now injury occurred	
Division	of or Attendia after death. Director: A	ertification;	3 Suicide 6 Could not be	8e. Place of Injury - At he building, etc. (Specification)	ome, farm, stre	et, factory, office		28f. Location (S City or Tow	Street and Number or	Rural Route Number,
Ö	urs after rel Direction	O								
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	edical	29a. Certifier (Check only one) Certifying Physicia 2 Medical Examiner:	In: To the best of my kno On the basis of examina and manner stated.	owledge, death ition and/or inv	occurred at the time estigation, in my op	e, date and plac inion, death occ	e, and due to the ourred at the time, of	cause(s) and manner date and place, and c	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed (Mo	nth, Day, Year)
) ,			JAM 5	hah Hire	en n	D De	51643		1/24/05	
1			30. Name and address of person who compl	eted cause of death (Item			7-1	erda	mn -	1702
	Sta	te	31. Date filed (Month, Pay) 4 200	32. Maistrar's Signa	J CV)	JY	Fred	encla	1100	1702
	Registr	ar	UNII N I LOU.	J. Williams	85° 6					

			For State Registrar	State of Maryland	/ Depa		lealth	and Men	tal Hygi		005	03800
	hysici /Medic		1. Decedent's Name (First, Middle, Lowell Lee					'	ate of Death Month	Day	Year 2005	3. Time of Death 1:40 P
	Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, o	r Location				nty of Death	1.40
			Anne Arundel Medi				nnapo	lis		Anne	e Arun	
	uneral rector			Sex 7. Age (In yrs. last	Yrs.	If Under 1 Year Months Days	Hours	Min. Ju	ne 24,	1923		olace (State or Foreign htry) ington D.C
aryiend	show	_	10a. State 10b. County	10c. City, To	own or Lo	ecation		-			1	10d. Inside City Limits
death with the Marylend	r 28a-f	Director	Maryland Anne Anne Anne Anne Anne Anne Anne An	rundel		Sher 10f. Zip Code	wood	Forest	10	g. Citizen o	of What Cour	1 ☐ Yes 2XXNo
th witi	23a o		754 Robin	Hood Hill		214	05		Ur	nited	State	:5
hours after dea	od other than "natural", or items 23a or 28a-f show event, the Modical Examiner must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No WWII If Yes, Give Year or Dates:	i	Was Decedent of Hif Yes, specify Cub	lispanic C an, Mexic Specif		Yes or No- n, etc.)	14. R B	ace - Americ lack, White, cify:	can Indian, etc. Thite
n 72 ho	"natur	Completed	15. Decedent's E (Specify only highest gi	ade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during mo	st of working	16	6b. Kind of	Business/In	dustry
CICIO- ed within 72 ygiane.	t, Ine M	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)		ical Pho	togra				ospita	1
vid be file Mental Hy	ked oth Ic even	To Be	17. Father's Name (First, Middle, Las Walter	" : Howell Lee, Sr.			18. Moti	her's Name <i>(Fir:</i> San	ah Was		-1	
g 2	Item 27 is marke other treumatic	-	19a. Informant's Name/Relationship	(Type, Print)		ng Address (Street	and Num					Code)
≥ ₽ €	r 1 2		Thomas Girard Lee			54 Robin	Hood					MD 21405
ages 1 nt of H	: If item		20a. Method of Disposition 1 ☐ Burial 2 ⑦ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec	Removal from State ceme	etery, crei	sition (Name of matory or other pla	· ·	Date			n - City or To	
permit. Pages Depertment of h	ortent injury 8.		* 4 □ Donation 5 □ Other (Spec 21. Signature of Fulheral Service Light	7000	_	e Cremate Name and Addre		A SECURE OF THE PARTY OF THE PA				Maryland al Home, In
Dep Dep	any ir		10 Michil	been						-		, MD 21401
/Me	sician edical miner		23a. Part1. Enter the disse, or cor shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. Due y (or as a consequence								Interval Between Onset and Death
te be executed	ysician end ne burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C								
	been signed by the attending physician end should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death	ath 3	Ectopic pregnanc	/			1	Pate of delive	ery Day Year
quires tha	uld be det	by	Part II. Other significant conditions		g in the u	/ /	ren in Pari Ufl	:I. :		cco use co 2 🗆 No		ne cause of death?
The lay	ate has	Completed	- Gemential	/ /					24a. Was an autopsy performe		prior to cor death?	psy findings available mpletion of cause of 2 2 No
Physicien: 7	ector,	Be	25. Was case referred to medical examiner?	Hospital:				e of Death (Ch.	eck only one)			
2 g	ral d	. To	1 Yes 2 No	1 Impatient 2DER	Outpatier b. Time of	nt 3 DOA Ott	4 🗆 🗅	lursing Home	5 🗌 Residen Describe how			y)
ding th.	: After	ation	1 Natural 5 Pending 2 Accident investigate	(Month, Day Year)	Injury	Wor	k? Yes 2[3000.100 1101	injury occi	21100	
To the Hospitel or Attending within 24 hours after death.	To the Funerel Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not 4 Homicide determined		, farm, str	eet, factory, office			ocation (Stre City or Town,		nber or Rura	l Route Number,
Hospite 24 hours	e Funere etely fille	Medical	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best of my knowled miner: On the basis of examination and manner stated.	dge, deatl and/or in	n occurred at the tir vestigation, in my o	ne, date a pinion, de	and place, and death occurred at	ue to the cau the time, date	se(s) and r e and place	manner as st e, and due to	tated. the cause(s)
To the	To the	Me	29b. Signature and title of certifier	// MID)	29c. Licens			290	1. Date sign	ined (Month,	Day, Year)
			30. Name and address of person wh	completed cause of death (Item 23)	а) (Туре,		100	2	1			
			Dafeet Cun	the Scelle 141	3 1	mipoli	Ko	af #	106 0	Men	tor K	1021113
	Sta Registr		31. Date filed (Month, Day, Year)	32. Redistrar's Signature								

DHMH 17 Rev 1/2001

ORIGINAL

Decedent's Name (First, Middle, Last) Facility Name (If not institution, give MEMORIAL HOS Social Security Number 6. Se 218 48 857 2 10 Social Security Number 6. Se Last 10b. County Maryland Caroline 9. Street and Number 12 Kitteridge Co Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edd (Specify only highest grac Elementary/Secondary (0-12) 12 Father's Name (First, Middle, Last) Garlton W. Bickline 1 Searlton W. Bickline 1 Burial 2 Cremation 3 1 2 Method of Disposition 1 Burial 2 Cremation 3 1 2 Method of Disposition 1 Burial 2 Cremation 3 1 3 Signature of Funeral Service License	street and number) SPITAL TARGE AND TARGE TO A SPITAL	16a. D. ((i)	If Under 1 Yea Months Days T Location boro 10f. Zip Code 216. 13. Was Decedent of If Yes, specify Cu 1 Yes 2 Needent's Usual Occilive kind of work don fe. DO NOT use retired to the code of the	39 Hispanic Originalisan, Mexican, For Specify: upation e during most original form of the during	P. Specify Yes or Nuerto Rican, etc.) Name (First, Middle or Rural Route Num Bld 4, A	Day Year 24 200 4c. County of Do TAI irth Pay, Year) 1948 Ma: 10g. Citizen of What USA 10g. Citizen of What USA 10g. Citizen of What USA 16b. Kind of Busine N/A 16b. Kind of Busine N/A 16b. Kind of Busine N/A 16b. Kind of Busine N/A 16b. Kind of Busine N/A 16b. Kind of Busine N/A 16c. Maiden Sumame) Mff Bickling Der, City or Town, State Pt 203 Deny	BOT Birthplace (State or Foreign Country) 10d. Inside City Limit 1 Yes 2 N Country? merican Indian, hite, etc. White ss/Industry
MEMORIAL HOS Social Security Number 6. Se 216 48 857 2 10 sual Residence of Decedent a. State 10b. County flaryland Caroline e. Street and Number 12 Kitteridge Co Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edit (Specify only highest grad Elementary/Secondary (0-12) 12 Father's Name (First, Middle, Last) Garlton W. Bickling a. Informant's Name/Relationship (7) Sheena Passan / da ta. Method of Disposition 1 Burial 2 Cremation 3 11 3 Under Specify 10 Other (Specify 10 Other (Specify 10 Other (Specify 11 Other (Specify 11 Other (Specify 12 Other (Specify 13 Other (Specify 15 Other (Specify 16 Other (Specify 16 Other (Specify 17 Other (Specify 17 Other (Specify 18 Other (Specify 18 Other (Specify 19 Other (Specify 19 Other (Specify 10 Other (Specify 10 Other (Specify 10 Other (Specify 10 Other (Specify 10 Other (Specify 10 Other (Specify 10 Other (Specify 10 Other (Specify 11 Other (Specify 11 Other (Specify 12 Other (Specify 12 Other (Specify 13 Other (Specify 14 Other (Specify 15 Other (Specify 16 Other (Specify 16 Other (Specify 17 Other (Specify 17 Other (Specify 18 Other (e Ourt 12. Was Decedent E Armed Forces? 1	56 Yrs 10c. City, Town of Greens ver in U.S. 16a. D	If Under 1 Yea Months Days T Location boro 10f. Zip Code 216. 13. Was Decedent of If Yes, specify Cu 1 Yes 2 Needent's Usual Occilive kind of work don fe. DO NOT use retired to the code of the	FASTO T If Under 24 S Hours 1 Hours 2 Hours 2 Hispanic Origin ban, Mexican, For Specify: upation e during most or red) 18. Mother's Georgat and Number of	P. Specify Yes or Nuerto Rican, etc.) Name (First, Middle or Rural Route Num Bld 4, A	TAI irth Pay, Year) 1948 Ma: 10g. Citizen of What USA 14. Race - A Black, W Specify: 16b. Kind of Busine N/A I. Maiden Sumame) uff Bicklin ber, City or Town, State pt 203 Deny	BOT Birthplace (State or Foreig Country) ryland 10d. Inside City Limit 1 N Yes 2 N Country? merican Indian, hite, etc. White ss/Industry
Social Security Number 2	e Ourt 12. Was Decedent E-Armed Frces? 1	56 Yrs 10c. City, Town of Greens ver in U.S. 16a. D	Months Days r Location boro 10f. Zip Code 216. 13. Was Decedent of If Yes, specify Cu 1 Yes 2 Ne secedent's Usual Occ live kind of work don fe. DO NOT use retir disabled lailing Address (Street 00 S. Will constitute (Name of	39 Hispanic Originiban, Mexican, For Specify: upation e during most or red) 18. Mother's Georg	Ris. B. Date of B. (Month, E. Oct 8) RY (Specify Yes or Nuerto Rican, etc.) Working Name (First, Middle of B. St. or Rural Route Num Bld 4, A	10g. Citizen of What USA 10- 16b. Kind of Busine N/A 1e, Maiden Sumame) uff Bicklin ber, City or Town, State pt 203 Deny	Birthplace (State or Foreig Country) ryland 10d. Inside City Limit 1 1 Yes 2 N Country? merican Indian, hite, etc. White ss/Industry
a. State 10b. County Idaryland Caroline e. Street and Number 12 Kitteridge Co. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest grace) Elementary/Secondary (0-12) 12 Father's Name (First, Middle, Last) Carlton W. Bickline Ba. Informant's Name/Relationship (T. Sheena Passan / data. Method of Disposition 1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify	e 12. Was Decedent E Armed Forces? 1	oreens Ver in U.S. 19b. M 13	boro 10f. Zip Code 216. 13. Was Decedent of If Yes, specify Cu 1 Yes 2 Needent's Usual Occibive kind of work don fe. DO NOT use retired in the Code of the Code	Hispanic Origin ban, Mexican, Fo Specify: upation e during most or red) 18. Mother's Georget and Number of	(Month, Doct 8) (Specify Yes or Note to Rican, etc.) (Working Name (First, Middle Sia R. St. or Rural Route Num Bld 4, A	10g. Citizen of What USA 14. Race - A. Black, W Specify: 16b. Kind of Busine N/A e, Maiden Sumame) uff Bicklin ber, City or Town, State pt 203 Deny	ryland 10d. Inside City Limit 1 Yes 2 N Country? merican Indian, hite, etc. White ss/Industry
Action W. Bickling and Informant's Name/Relationship (T. Sheena Passan / da Method of Disposition 1 Burial 2 Caroline (Specify only highest grace) Burial 2 Caroline (Specify only highest grace) Ca	e Ourt 12. Was Decedent E Armed Forces? 1	Greens verin U.S. 16a. D (C) 19b. M	boro 10f. Zip Code 216. 13. Was Decedent of If Yes, specify Cu 1 Yes 2 No. 10 Yes 2	Hispanic Origin ban, Mexican, Fo Specify: upation e during most or ed) 18. Mother's Georget and Number of	Name (First, Middle gia R. St or Rural Route Num Bld 4, A	USA 14. Race - A. Black, W Specify: 16b. Kind of Busine N/A e. Maiden Sumame) uff Bicklin ber, City or Town, State pt 203 Deny	1 N Yes 2 N Country? merican Indian, hite, etc. White ss/Industry
e. Street and Number 12 Kitteridge Co. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edic (Specify only highest grace) Elementary/Secondary (0-12) 12 Father's Name (First, Middle, Last) Garlton W. Bicklin Ba. Informant's Name/Relationship (7) Sheena Passan / data Method of Disposition 1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify	Durt 12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: ucation de completed) College (1-4or 5+ ng ype, Print) aughter Removal from State	16a. D. (()	10f. Zip Code 216 216 13. Was Decedent of If Yes, specify Cu 1 Yes 2 Ne ecedent's Usual Occive kind of work don fe. DO NOT use retir disabled lailing Address (Street 00 S. Will	Hispanic Origin ban, Mexican, Fo Specify: upation e during most or ed) 18. Mother's Georget and Number of	Name (First, Middle gia R. St or Rural Route Num Bld 4, A	USA 14. Race - A. Black, W Specify: 16b. Kind of Busine N/A e. Maiden Sumame) uff Bicklin ber, City or Town, State pt 203 Deny	Country? merican Indian, hite, etc. White ss/Industry
**Author of Disposition **Author of Dispositi	12. Was Decedent E Armed Forces? 1	16a. D. ((i)	216. 13. Was Decedent of If Yes, specify Cu 1 Yes 2 Neecedent's Usual Occive kind of work don fe. DO NOT use retired is abled Italian Address (Street) OO S. Willers (Neecedent)	Hispanic Origin ban, Mexican, Fo Specify: upation e during most or ed) 18. Mother's Georget and Number of	Name (First, Middle gia R. St or Rural Route Num Bld 4, A	USA 14. Race - A. Black, W Specify: 16b. Kind of Busine N/A e. Maiden Sumame) uff Bicklin ber, City or Town, State pt 203 Deny	merican Indian, thite, etc. White ss/Industry
Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edit (Specify only highest grace) 12 Father's Name (First, Middle, Last) Carlton W. Bickling a. Informant's Name/Relationship (T. Sheena Passan / data. Method of Disposition 1 Burial 2 Cremation 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	12. Was Decedent E Armed Forces? 1	16a. D. ((i)	13. Was Decedent of If Yes, specify Cu 1 □ Yes 2 ☑ No secedent's Usual Occ live kind of work don be. DO NOT use retir disabled lailing Address (Street 00 S. Will	Hispanic Originiban, Mexican, Fo Specify: upation e during most or red) 18. Mother's Georgal and Number of	Name (First, Middle gia R. St or Rural Route Num Bld 4, A	14. Race - A. Black, W Specify: 16b. Kind of Busine N/A N/A N/A N/A N/A N/A N/A N/	white ss/Industry ng a, Zip Code)
3 Widowed 4 Divorced 15. Decedent's Edit (Specify only highest grace) Elementary/Secondary (0-12) 12 Father's Name (First, Middle, Last) Garlton W. Bickling a. Informant's Name/Relationship (T) Sheena Passan / day a. Method of Disposition 1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify,	It Yes, Give Year or Dates: ucation to completed) College (1-4or 5+ ng type, Print) aughter Removal from State	16a. D. (C. lii)	acedent's Usual Occive kind of work don to. DO NOT use retired is abled disabled dailing Address (Street OO S. Will	upation e during most or red) 18. Mother's Georg	Name (First, Middle gia R. St or Rural Route Num Bld 4, A	Specify: 16b. Kind of Busine N/A N/A N/A Specify: N/A Speci	White sss/Industry ng a, Zip Code)
(Specify only highest grace (Specify only highest grace 12 12 12 Father's Name (First, Middle, Last) Carlton W. Bicklin Ba. Informant's Name/Relationship (Tight) Sheena Passan / da a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify, 1988)	ng ype, Print) aughter Removal from State	19b. M	disabled lailing Address (Street OO S. Will	18. Mother's Georget and Number of	Name (First, Middle gia R. St or Rural Route Num Bld 4, A	N/A e, Maiden Sumame) uff Bicklin ber, City or Town, State pt 203 Deny	ng a, Zip Code)
Father's Name (First, Middle, Last) Carlton W. Bicklin Da. Informant's Name/Relationship (T) Theena Passan / da a. Method of Disposition 1 □ Burial 2 Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify,	ype, Print) aughter Removal from State	19b. M 13	lailing Address (Stree	Georg	gia R. St or Rural Route Num Bld 4, A	e, Maiden Sumame) uff Bicklin ber, City or Town, State pt 203 Den	e, Zip Code)
Carlton W. Bicklin Ba. Informant's Name/Relationship (T) Cheena Passan / da a. Method of Disposition 1 Burial 2 Coremation 3	ype, Print) aughter Removal from State	13	00 S. Will	Georg	gia R. St or Rural Route Num Bld 4, A	uff Bicklin ber, City or Town, State pt 203 Deny	e, Zip Code)
Pa. Informant's Name/Relationship (T) Sheena Passan / da a. Method of Disposition 1 □ Burial 2 Cremation 3 □ 1 `4 □ Donation 5 □ Other (Specify,	ype, Print) aughter Removal from State	13	00 S. Will	et and Number o	Bld 4, A	ber, City or Town, State pt 203 Den	e, Zip Code)
a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	20h Plana of D	icposition (Alama of	low St.			ver, CO 8024
1 ☐ Burial 2 🛣 Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,)	20b. Place of D	isposition (Name of crematory or other pi		Date.		
		Chacana		lace)	Date	20c. Location - City	or Town, State
1. Signature or Furieral Service License	200	onesape			an 27, 05	Chester, Ma	aryland
			22. Name and Add		enbein Fu	neral Home, 21639	PA
equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last	c. Hu	PSC75	NSIAN	c Fra	ILVRE		
FEMALE: 3b. Was decedent pregnant in the past 12 moves? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live birth 2	Fetal death	3 □Ectopic pregnan 5 □ Other (specify)	icy		23d. Date of o	delivery Day Year
art II. Other significant conditions co	ontributing to death bu	t not resulting in th	ne underlying cause g	given in Part I.			to the cause of death? Probably 4 Unknown
					— aut	opsy prior death	autopsy findings available to completion of cause of ? Yes 2 \(\sum \) No
5. Was case referred to medical examiner?	Hospital:			than			
7. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	/28b. Tim	ne of 28c. Injury W	ury at	28d. Describe		pecify)
2	28e. Place of Injur	ry · At home, farm (Specify)			28f. Location	(Street and Number or own, State)	Rural Route Number,
(Check only 2 Medical Exam	iner: On the basis of	examination and/	death occurred at the or investigation, in my	time, date and p	place, and due to the occurred at the time	e cause(s) and manner a, date and place, and c	as stated. due to the cause(s)
9b. Signature and title of certifier			29c. Lice	nse number		29d. Date signed (Mo	onth, Day, Year)
			I da	>57	988	1/2	6/05
D. Name and address of person who o	complete cause of de	ath (Item 23a) (Ty	CCH	5 /	OLDITBO	10 . N	À
3	FEMALE: b. Was decedent pregnant in the past 12 monts? 1	Any, leading to immediate use. Enter Underlying use (Disease or injury at initiated events sulting in death) Last FEMALE: b. Was decedent pregnant in the past 12 moorts? 1 Yes 2 No 9 Unknown It ii. Other significant conditions contributing to death but a leading to the pregnant of the past 12 moorts? All Pregnant at the pregnant of the past 12 moorts? It is the past 12 moorts? It is the past 12 moorts? All Pregnant at the pregnant of the pregnant at the past 12 moorts of the pregnant at the pregnan	Any, leading to immediate use. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of prediction of predicti	Less Enter Underlying aluse (Disease or injury at initiated events sulting in death) Last Due to (or as a consequence of): Less Enter Underlying aluse (Disease or injury at initiated events sulting in death) Last Due to (or as a consequence of): Due to (or as a consequence	Lose for for underlying use. Enter Underlying use (Disease or injury at initiated events sulting in death) Last Due to (or as a consequence of): Consider the past 12 months Consider the past 13 months Consider the past 14 months Consider the past 15 months Conside	Due to (or as a consequence of): d. Continue Con	Let of the death of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. Was case referred to medical examiner? Was case referred to medical examiner of the Hospital: 1 Inpatient 2 ER/Outpatient 3 DoA Chier: 4 Nursing Home 5 Pending investigation 3 Suicide 5 Pending investigation 3 Suicide 5 Pending investigation 3 Suicide 5 Pending investigation 3 Suicide 5 Pending investigation 3 Suicide 5 Pending investigation 3 Suicide 5 Pending investigation 28a. Date of Injury At home, farm, street, factory, office 28f. Location (Street and Number or Chy or Town, State) 28b. Date of death occurred at the time, date and place, and due to the cause (s) and manner of the same of the

				riease (-						III Copie: Mental Hy		•	0.000
			For State Registrar			,		rtificate				Reg. No.	005	03802
	Obvojsi	-	1. Decedent's Name (First,	Middle, Last,)						2. Date of D Month		Yeer	3. Time of Death
	Physici /Medic		JOHN BI				ART				1	22	2005	1400 M
	Examin	er	4a. Facility Name (If not ins Atlantic						own, or L Berli	ocation of Deat	n		ounty of Death	r
	Funeral	- 6	5. Social Security Number	6. Se:	x	. Age (In yrs	last birthday)	If Under 1		If Under 24 Hrs. Hours Min.	8. Date of B	irth		place (Stete or Foreign
	Director		102-30-216 Usual Residence of Decede	3	(M 2□F	77	Yrs.	.v.o.iiiio	ou, o	1100.0	1/12/		Irela	
	yland now		10a. State 10b. C	ounty		10c. C	ity, Town or Lo							10d. Inside City Limits
	e Mar	Funeral Director	MD W	orcest	er		Berli	n						Yes 2□No
	with th	Dire	10e. Street and Number		D.D.			10f. Zip (- 51	n of What Cou	ntry?
	ms 23	era	4 King Ric			dent Ever in t	J.S. 13.		21811 ent of Hisp	panic Origin? (S	pecify Yes or N o Rican, etc.)		SA . Race - Americ	
99	or Ite		1 Never Married 2		12. Was Deced Armed For 1 Tes If Yes, Give	085? 2 [X No		fYes, speci 1 ☐ Yes 2		Mexican, Puert Specify:	o Rican, etc.)		Black, White, pecify: W	etc. hite
21215-0036	itied within 72 hours after death with the Maryland Hygiene. ither than "natural", or Items 23a or 28a-f ehow int, tra Medical Examinat must be notified at	ed by	3 Widowed 4 Div	cedent's Edu	Year or Da	tes:		dent's Usual					of Business/In	
215	d within 72 ho piene. r than "natur ine Medical	Completed	(Specify only Elementary/Secondary (0	highest grad	e completed) College (1-	4or 5+)	(Give	kind of work DO NOT use	done dui e retired)	ring most of wor	king	TOD. KING	01 20011000	oustry
213	e fited within Hygiene. other then	Con			4		Ac	count					·	ion Co.
and	e d al	Be c	17. Father's Name (First, M		art				1	8. Mother's Nar Mary	ne <i>(First, Middle</i> Lynch	a, Meiden Su	ımame)	
6) Maryland	d 2 should be the and Mental I is marked of traumatic ever	Ţ	19a. Informant's Name/Rel				19b. Mailir	ng Address ((Street and		ral Route Numi	ber, City or T	own, State, Zip	Code)
			Marie Mo	Enteg	art					ard RD	Berlin,	_	21811	
#494(b)			20a. Method of Disposition	ation 3 □F	Removal from S	tate	Place of Dispo	natory or oth	her place)		6/05		tion - City or To	
It in			° 4 □ Donation 5 □ Ott			Ci	•	•		ematory			nkford,	
# Ba	permit. Departr Importe any inje		W. Frie	Bu	ulas		1	08 Wil	lliam	St. Be	Burbac rlin, Mi	ge Fui D 218	neral H 311	ome
3			23a. Part 1. Enter the diseast shock, or heart failure	se, or compl List only or	ications that ca ne cause on ea	used the dea								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)		Ser	otic	Shock	C						Onset and Death
40,	/Medical Examiner		,		Due to (c	r as a conse	quence of):	Anto.	ctror	2				
204	* *	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	, J	Due to (c	r as a conse		1	4101	•				•
	be executed ician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	· Colo	or as a conse	ance/				_			
1525 600,		E		l.	4	as a conse	querice or).							
17/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2	tificate ig phy: as the	ledic			o									
1/2 Box	leath certificate attending phys I for use as the	an/N	IF FEMALE: 23b. Was decedent pregna in the past 12 months	it it		th 2 Fet	al death 3 □	Ectopic pre				230	d. Date of delive	ory Day Year
000	he dea the al	Physician/Medic	1 Yes 2 No 9 Unknown		4□ Pregna 9□ Unkno	nt at time of one	death 5□	Other (spe	cify)				MONTH	Day 16a1
S, P.	w requires that the s been signed by the should be detache	by Ph	Part II. Other significant co	nditions cor	ntributing to dea	ath but not re	sulting in the u	nderlying car	use given	in Part I.	23e. Did	tobacco use	contribute to th	ne cause of death?
G-ART ecords	equire en sig ould b										1 🗆	Yes 2□	No 3 □ Prob	ably 4 Onknown
G 9	e lawr has be ge 2 sh	Completed									24a. Was	s an 2	24b. Were auto	psy findings available impletion of cause of
163 163 al R	sician: The certificate har rector, page		05.14								1 ☐ Yes	2 No	1 Yes	2 No
-216 Vital	ysicial is certil directo	To Be	25. Was case referred to mexaminer? 1 ☐ Yes 2 ☐ No	_	Hospital: 1 1710	patient 2] ER/Outpatien	t 3 DOA	Other		th (Check only ome 5 ☐ Res		Other (Sensif	- Indiana in the Indi
30 - 30 -	ding Phy h. After thi funeral c		27. Manner of Death	Pending	28a. Date of		28b. Time of		c. Injury at Work?		28d. Describe			,,
Ser ision	Attendir death. ctor: Af y the fu	catic	2 Accident	nvestigation Could not be				М	1 🗌 Ye	s 2 No				
John 1	for Atten after deat Director:	Certification:	4 Homicide	letermined	28e. Płace o buildin	of Injury - At h g, etc. <i>(Speci</i>	iome, farm, str ify)	eet, factory,	office		28f. Location (City or To	(Street and Newn, State)	iumber or Rura	l Route Number,
_ 1	The Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Saic	29a. Certifier 1 Ce	rtifying Phy	sician: To the I	pest of my kn	owledge, death	occurred at	t the time,	date and place	, and due to the	cause(s) an	d manner as si	ated.
35	the Fi	Medical	one)		ner: On the ba	sis of examination of stated.	ation and/or inv				rred at the time.			
	22 vity Con	-	29b. Signature and title of o	эплег	712	110		29c.	License n	3 / 2.—		29d. Date s	igned (Month,	Oc. 5
			30. Name and address of p	erson who co	ompleted cause	of death (Ite	m 23a) (Type	Print》	100	- /		01/	- / -	
ε	T10		Gregory &	Stam	inas, 1	ND	9733	Heal	theva	ig Drive	- BE	-lin,	WD 3	(181)
	Sta Registr		31. Date filed Month/Day,		005 32. R	gistrar's Sign	ature	Caroli 1	,	,				

Philip Fendall Marbury As Facility Name (Incomitations, piece street and number) As Facility Name (Incomitations, piece street and number) As Facility Name (Incomitations, piece street and number) As Facility Name (Incomitations, piece street and number) As Facility Name (Incomitations) As Facility Name (Incomitatio		1 - State Registrar	yland / Dep	artment of Health and Martificate of Death	Mental Hygier	ne 2005 0300
Social Social	ledical.	· · · · · · · · · · · · · · · · · · ·		4b. City. Town or Location of Death		
100. Cliffy Town of Localition 100. Cliffy Town of Localition	eral	Washington County Hospital 5. Social Security Number 6. Sex 7. Age (Hagerstown If Under 1 Year If Under 24 Hrs.		Washington 9. Birthplace (State or Forei
15. Decedent's Stuation (Speech, orn) impliest grade completed) 16. Gever and device done dangement of working (Speech, orn) impliest grade completed) 16. Gever and device done dangement of working (Speech, orn) impliest grade completed) 16. Gever and device done day on the order of working (Speech, orn) impliest grade completed) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Masider Sumame) 18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Masider Sumame) 18. Informant's Name-Relationship (Type, Print) 18. Informant's Name-Relationship (Type, Print) 18. Mother's Name (First, Middle, Masider Sumame) 18. Mother's Name (First, Middle, Masider Sumame) 18. Mother's Name (First, Middle, Masider Sumame) 18. Mother's Name (First, Middle, Masider Sumame) 18. Mother's Name (First, Middle, Masider Sumame) 18. Mother's Name (First, Middle, Masider Sumame) 18. Mother's Name (First, Middle, Masider Sumame) 18. Mother's Name (First, Middle, Masider Sumame) 18. Mother's Name (First, Middle,	tor	10a. State 10b. County 1				10d. Inside City Lim 1√2 Yes 2 ☐ I
15. Decederits Education Specific or Impliest grade completed) 16. Specific or Impliest grade completed) 16. Specific or Impliest grade completed) 16. Specific or Impliest grade completed) 16. Specific or Impliest grade completed) 16. Specific or Impliest grade completed) 16. Specific or Impliest grade completed) 16. Specific or Impliest grade completed) 16. Specific or Impliest grade completed) 16. Specific or Impliest grade completed) 16. Specific or Impliest grade completed) 16. Specific or Impliest grade completed grade gr	al Direc				10g.	•
15. Decedents Susaid Occupation 16. Rind of Business/Industry 16. Rind of Business/Indus	by Funer	Armed Forces? 1 ▼ Never Married 2 Married 1 □ Yes 2 ▼ No		_	pecify Yes or No- Rican, etc.)	Black, White, etc.
17. Father's Name (First, Middle, Macken Sumans) 18. Monique Boissonnas 18. Monique Boisso	ompleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Unk	16a. Dece (Give life.	kind of work done during most of work DO NOT use retired)	sing 16b.	,
Isabel Marbury-Mauro/Sister 2986 Glenora Lane, Rockville, MD 20850	Be	Fendall Marbury		18. Mother's Nam Moniqu	e Boisson	len Surname) NAS
Smithsburg Cremator. 01/31/2005 Smithsburg, MD 21. Signature of Juneral Student Stude		Isabel Marbury-Mauro/Sister	2986	Glenora Lane, Roc	kville, M	20850
23a Part. Enter the distrise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, approximate interval Beach disease or condition and disease or condition resulting in death) is condition. Sequentially list conditions. Due to (or as a consequence of): Circula Duy, collapse Sequentially list conditions. Due to (or as a consequence of): Circula Duy, collapse Cause (Disease or injury resulting in death) Last Due to (or as a consequence of): Circula Duy, collapse Cause (Disease or injury resulting in death) Last Due to (or as a consequence of): Circula Duy, collapse Cause (Disease or injury resulting in death) Last Due to (or as a consequence of): Circula Duy, collapse Cause (Disease or injury resulting in death) Last Due to (or as a consequence of): Circula Duy, collapse Cause (Disease or injury resulting in death) Last Due to (or as a consequence of): Circula Duy, collapse Cause (Disease or injury resulting in death) Last Due to (or as a consequence of): Circula Duy, collapse Cause (Disease or injury resulting in death) Last Due to (or as a consequence of): Circula Duy, collapse Cause (Disease or injury resulting in death or collapse) Due to (or as a consequence of): Circula Duy, collapse Cause (Disease or injury resulting in the underlying cause given in Part I. 23d. Date of delivery Month Day Y. 1 Yes 2 No. 24a. Was an audopsy performed? Part II. Other significant conditions contribute to the cause of death collapse in completion of cause of the consequence of): 24a. Was an audopsy performed? Part II. Other significant conditions contribute to the cause of death collapse in consequence of): 25. Was case referred to medical examiner: 27. Manger of Death Month Day Y. 28a. Flace of Death (Check on Arone) Check on your performed of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the	nce.	* 4 □ Donation 5 □ Other (Specify)	Smithsbur	rg Cremator. 01/31		
238. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 239. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I. 240. Was an autopsy performed? 241. Was an autopsy performed? 251. Was case referred to medical examiner? 252. Was case referred to medical examiner? 253. Did tobacco use contribute to the cause of death prior to completion of cause of the cause of death? 254. Was an autopsy findings a prior to completion of cause of the cause of death? 255. Was case referred to medical examiner? 256. Place of Death (Check only one) 257. Manner of Death 268. Injury at Work? 278. Injury at Work? 280. Describe how injury occurred 281. Location (Street and Number or Rural Route Number of House) 283. Did tobacco use contribute to the cause of death prior to completion of cause of the cause of death? 244. Was an autopsy findings a prior to completion of cause of the completion of cause of the completion of cause of the cause of death? 255. Was case referred to medical examiner? 256. Place of Death (Check only one) 257. Manner of Death 258. Death (Check only one) 258. Death (Check only one) 269. Place of Death (Check only one) 270. Manner of Death 270. Manner of Dea	lcal Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Severe Due to (or as a condition of the cond	Cerebral consequence of): a tory	anoxic damage	2	Approximate Interval Between Onset and Death Cays Gays Gays
238. Did tobacco use contribute to the cause of death out not resulting in the underlying cause given in Part I. 239. Did tobacco use contribute to the cause of death of death of the cause of death of death of the cause of death of death of the cause of death of death of death of the cause of death of death of death of the cause of death of	yslclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 [4 □ Pregnant at times of 1 □ Ves the part of 1 □ Ves birth 2 [4 □ Pregnant at times of 1 □ Pregnant at times of 1 □ Ves birth 2 [4 □ Pregnant at times of 1 □ Pregnant at times of 1 □ Pregnant at times of 1 □ Pregnant at times of 1 □ Pregnant at times of 1 □ Pregnant at times of 1 □ Pregnant at times of 1 □ Pregnant at times of 1 □ Pregnant at times of 1 □ Pr	Fetal death 3			
autopsy performed? Performed Performe	by	Part II. Other significant conditions contributing to death but r	not resulting in the u	nderlying cause given in Part I.		V-
examiner? 1 Yes 2 10 Hospital: 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 27. Namer of Death 2 28a. late of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28a. late of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28a. late of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28a. late of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28a. late of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number of Rural Ro					autopsy performed?	24b. Were autopsy findings availab prior to completion of cause of death? 1
O 200 Codificer 12 Codificing Physicians To the heat of an Installation death and a the time data and a large series and a larg	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury	28b. Time of Injury	Other: 4 Nursing Ho 28c. Injury at Work? M 1 Yes 2 No	me 5 Residence 28d. Describe how in 28f. Location (Street	jury occurred and Number or Rural Route Number,
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 71N 20 200	5	(Check only 2 Medical Exeminer: On the basis of every one) and manner states	camination and/or in	vestigation, in my opinion, death occur	red at the time, date a	and place, and due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBIERT BRULL 1459 POTOMAC ST. HAGERSTOWN, MB 2/742	No.	Robert Brull AD Person	rd Physica	in D 0004.	359	TAN 29 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Jan. **Physician** EARL THOMAS MORRIS Ĭ9, 2005 3:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Nursing and Rehab Center
5. Social Security Number | 6. Sex | 7. Age (In yrs. last bit Salisbury, Md. W.

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Wicomico 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Director 214-28-8712 74 April 1. 1930 MARYLAND Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show The Wedicul Examination is the notified at 1 ☐ Yes 2X No Directo MARYLAND WICOMICO <u>SALISBURY</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7596 BUCKMAN AVENUE 21801 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than College (1-4or 5+) Elementary/Secondary (0-12) LABORER 6th FARM INDUSTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fit ment of Health and Mental H tant: If Item 27 is marked off Be HARLAN MORRIS JULIA RIDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick Morris/nephew 4045 The Alameda, Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If Ite any injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Springhill Mem. Gdns 01/29/2005 Hebron, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD JOLLEY MEMORIAL CHAPEL 23a. Part 1. Enter the disease, or compileations that caused the shock, or heart failure. List only one cause on each line. caused the dea Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** oncer ear /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 01 Due or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 donknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? certificate 2 No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No in by the f 2 Accident Director: 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Las 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM ROBINS, M.D. 200 CIVIC AVE., SALISBURY, MD. 21804 31. Date filed (Month, Day, Year) JAN 2 6 32. Revistrar's Signature State ABBURE.

DHMH 17 Rev 1/2001

Registrar

			State of Maryland / Department of Health and M 1- State Registrar State of Maryland / Department of Health and M Certificate of Death	lental Hy	giene	2005	5_038n
П	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of De Month	Day	Year	3. Time of Death
	/Medic Examin		Thomas H. Mooney, Sr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	January		2005 ounty of Death	1:20 a. "
8	Funeral Director			8. Date of Bir (Month, Da	th ly, Year)	ntgomer ^{9. Birth} <i>Cou</i> 20 Char	y place (State or Foreign ntry) lestown, WV
	yland Now		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Ba-f sh	ector	MD Montgomery Montgomery Village		- <u></u>		1 ☐ Yes 2X No
920	ba filed within 72 hours after death with the Maryland ital Hygiene. id other than "neturel", or Items 23s or 28s-f show event, the Micifiel Examination to the modified at	by Funeral Director	10e. Street and Number 10f. Zip Code 19301 Watkins Mill Road 1. Marital Status 1 Never Married 2 Married XXWidowed 4 Divorced 10f. Zip Code 20886 12. Was Decedent Ever in U.S. Armed Forces? 1 Never in U.S. Armed Forces?	ecify Yes or No Rican, etc.))- 14.	USA . Race - Ameri Black, White,	can Indian,
21215-0036	within 72 ho ene. than "netur he Mcdical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired)	ing	16b. Kind	of Business/In	
121	a filed within al Hygiene. I other than vent, the ve		12 Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name	/Eirst Middle		ASA	
Maryland	lid ba f fental l rked o	To Be	Joseph Jack Mooney Nannie			imame)	
lary	2 should ba and Mental Is marked eumatic ev		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura			own, State, Zip	Code)
Baltimore, N	parmit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marke any injury or other treumatic 2008.		1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)	Date	20c. Loca	tion - City or To	own, State
ıtir	nit. Pa artmer ortant injury e.		'4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery Jan. 21. Signature Funeral Servi, License 22. Name and Address of Facilit Gasc	27. 05	Suit	land, l	Maryland
ä	Depared Important in Superior		Aveit ///au 4739 Baltimore Aven	ue, Hya	attsvi		
	Pnysician /Medical		23a! Pant 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cruse on each line. Immediate Cause (Final disease or condition resulting in death)		_		Approximate Interval Between Onset and Death
8760,	be executed ician and purial-transit	Ilcal Examiner	Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				
O. Box 6	ath certific ttending p or use as	Physiclan/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown		230	d. Date of delive Month	ery Day Year
σ.	w raquires that the de been signad by the s should be detached t	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use		ne cause of death?
Vital Records	The law ate has b page 2 st	Completed			an 2 osy rmed? 2 3 No	24b. Were auto prior to co- death? 1 \(\text{Yes}	psy findings available mpletion of cause of 2 No
		o Be	25. Was case referred to medical examiner? 1 Yes 2 No			Other (Specif	iv)
ion of	Attending Physic death. sctor: After this by the funeral di	atlon: T		28d. Describe h			,,
Division	in Pite	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (5 City or Tox	Street and N vn, State)	Vumber or Rura	l Route Number,
	he Hospitel in 24 hours a he Funeret I pletely filled	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the e	cause(s) an date and pla	d manner as si ace, and due to	tated. the cause(s)
	To the He within 24 To the 50 completel	Σ	29b. Signature and title of cetifier 29c. License number			igned (Month,	
	(5)0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ටර	()	- 25 -	O (7)
	Sta	to.	Anushiravan Dadgar, D.O. 9715 Medical Center Dr., Suing 31. Date filed (Month, Day, Year)	te 201,	_Rock	ville,	MD 20850
	Sta Registr	100	JAN 2 6 2005 32. Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 **Physician** January 2:16 LOTTIE MASLEK /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Kline Hospice House Carroll 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 ☐ F Yrs 96 094-14-8507 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ral', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Mt. Airy Maryland Carrol1 Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21771 7000 Kimmel Road U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 8 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alexander Kozlowski Mary Gieszkiewicz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 124 Catoctin Avenue, Thurmont, MD 21788 (Daughter) Dorothy Kos item 27 I 20b. Place of Disposition (Name of centratery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot. 1 Burial 2 Cremation 3 Removal from State Trinity Cemetery 1/29/05 Holf Lewiston, New York ' 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune a Syrvice ROBERT E. DATLEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part 1. Enter the disease, or complicators that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ATherosclerofic (Andro Vasculan **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ director, page 2 should be EMENTIA 1 Yes 2 No 3 Probably 4, Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2 - NO 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Dther: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending Natural investigation 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10035152 1. 24.05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thurmont, MD 21788 100 MO KIGATZ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 4 Registrar

State of Maryland / Department of Health and Mental Hygiene 03807 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 20, **Physician** John Parker Minor Jan. 5:45 a /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FutureCare Chesapeake Arnold Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 1X M 2□ F 86 Yrs. 231-01-2962 9, 1918 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or items 23a or 28a-f ahov the Medical Examiner must be notified at MD Anne Arundel 1 Tyes 2 Tho Director Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 College Pkwy 21012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married IIWW 1 ☐ Yes 2 No White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman/Designer St. Joe Paper Co. permit. Pages 1 and 2 should be life Depertment of Heelth and Mental Hy important: if item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Herbert Minor Alma Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Kappel/Daughter 218 Arundel Beach Road, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Jan. 21, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory Baltimore, MD * 4 □ Donation 5 □ Other (Specify) 2005 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licensee 23a Port1. Enter the disease, of complications that caused in shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical inary tract infection mon Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physicien and the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ disease, 1 Yes 2 □ No 3 Probably 4 Unknown Completed peen ree amputation, ischemi 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform cardiomyopathy chronic lung disease 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: Certification; To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident Injury 5 Pending 1 Yes 2 No investigation 6 Could not be determined 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Reservant address of person who completed cause of death (Item 23a) (Type, Print)

Reservant Highway #204

Registrar

		1 - For State Registrar	State of Maryl	and / Dep		t of H	ealth an	d Mental Hy		005	03808
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, La Pau E N 4a. Facility Name (If not institution, give	re street and number)		4b. City,	Town, or	Location of D	2. Date of Do Month Jan eath	18 4c. 0	Year 2005 County of Dea	9:00 A
Funeral Director				vrs. last birthday) Yrs.			erstor If Under 24 I Hours M	Hrs. 8. Date of Bi (Month, Di	rth ay, Year)		rthplace (State or Fore country)
se Maryland Ba-f show atilied at	Director	10a. State 10b. County Maryland Washing		City, Town or Lo	own						10d. Inside City Limi
th with the 23a or 2	ai Dire	10e. Street and Number 14014 Marsh Road	đ		10f. Zip	Code 1740			10g. Citize	on of What C	country?
hin 72 hours after death with the Maryland 9. an "natural", or items 23a or 28a-f show Medical Examiner must be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 MYes 2 Not 9	142	Was Deced If Yes, spec 1 ☐ Yes		spanic Origin? n, Mexican, Pi Specify:	? (Specify Yes or No uerto Rican, etc.)		Black, Wh	erican Indian, ite, etc. Thite
hin 72 9. Medic	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		(Give	dent's Usua kind of wor DO NOT us achin	rk done d se retired,	ition luring most of)	working		of Business	•
ould be filed wit Mental Hygiene arked othar the atic avant, the	To Be Co	Unknown 17. Father's Name (First, Middle, Last David A. Monn)		,		Bess	Name (First, Middle	, Maiden S alime	umame)	
and 2 should ealth and Mer n 27 ia marke ier traumatic		19a. Informant's Name/Relationship Eileen Parker (Ni	Type, Print) Leces)					Rural Route Numb			Zip Code)
mit. Pages 1 and partment of Healt cortant: If item 2: injury or other is:		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Speci	(v)	b. Place of Dispo cemetery, cre-	Hi11 ('emel	Jar	Date 1. 28, 200	05 Way	ynesbo	r Town, State
permit. Departr Imports any inju		21. Signature of Juneral Ser. 6. Lice	nsee Paul T. Ions	tampfor 2	LOCHS	dage Pipa	OR FUN	VERAL HOMI , Waynesi	E,INC	PA172	68
Physician /Medical		23a. Part T. Enter the disease or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the door one cause on each line. A SCVD Due to (or as a con		ter the mod	e of dying	g, such as care	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
ate be executed ysician and he burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CHF Due to (or as a con c. Enasta Due to (or as a con Diabeter	20 C 541	,		ΔυΔ		_		Chronic Chronic
dearn certificate to attending physical for use as the to	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	gnancy Fetal death 3 [□Ectopic pro□ Other (sp	egnancy	12/		23	d. Date of de Month	
gne	þ	9 ☐ Unknown Part II. Other significant conditions	9□ Unknown contributing to death but not	resulting in the u	inderlying ca	ause give	n in Part I.	23e. Did	/		o the cause of death?
ate h	Completed							1 ☐ Yes	psy ormed? 2 No	24b. Were a prior to death?	
ng Phy fter this	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 Do 27. Manner of Death 1 Matural 5 Pending investigatic investigatic	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	28b. Time o		8c. Injury Work	r: 4 V ursin	Death (Check only of the second of the secon	dence 6		ecify)
or Attan iter dea irector n by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not to determined	99 Place of Injury . A	At home, farm, st ecily)				28f. Location (City or To		Number or R	tural Route Number,
To the Hospital of within 24 hours at To tha Funeral D completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa 29b. Signature and title of certifier)	hysician: To the best of my miner: On the basis of exan and manner stated.	knowledge, deat nination and/or in	vestigation,	at the tim in my op	inion, death o	ace, and due to the ccurred at the time,	date and p	lace, and du	s stated. e to the cause(s) th, Day, Year)
4.3	_	1 126	completed source of door.	Itom (20s) (T	D	006	52223		6	05	, Day, 1001)
511		30. Name and address of pe on who 340 Mill S 31. Date filed (Month, Day, Year)	t., Hagerstov 32. Region Si	wn, Md 2		Dr.	Bolaru	m			
Star Registra			2005	Re	10-	2					

State of Maryland / Department of Health and Mental Hygiene 🎧 🕦 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Beulah Virginia Martin January 31 2005 1:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year Jun 18, 1 Birthplace (State or Foreign Country) **Funeral** 1 M 2XX 219-07-4923 90 Director Mary land Usual Residence of Decedent filed within 72 hours efter death with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🛣 No Maryland Frederick Frederick **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7424 Down Hill Run 21702 U.S.A. 238 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or itame 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: White 3 XWidowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filled v Department of Heelth end Mental Hygien Importent: if Item 27 is marked other it eny injury or other treumatic event, Iths once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maurice Blank Eugene Elmira Annie Stockman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Victor E. Masser / Son 7424 Down Hill Run, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rocky Springs Cemetery Feb 3,2005 Frederick, Maryland 1 4 □ Donation 5 □ Other (Specify) 21. Sign. tu. of Funeral Service Liner see 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 M00706 An Rottern 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) esebro Varcellar SINKE Days. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Be Completed by Physician/Medical Examiner Due to (or as a consequence of). burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. inding physical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Dav Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ZNo 3 ☐ Probably 4 ☐ Unknown PAYTENTION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes mellitus autopsy performed 2 No 1 Yes 2 No 1 TYAS Division of Vital Hospitel or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Ceath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 ☑ Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No hours efter death. unerel Director: A investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide within 24 hours e To the Funerel C TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical (Check one) 29b. Signature 29d. Date signed (Month, Day, Year) and title of certifier 29c. License number tren Shah, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 65 [honson 31. Date filed (Month, Day, Year) State Registrar FEB 8 2005

State of Maryland / Department of Health and Mental Hygiene Amend Item 23a per Dr., G842,04/25/05dbb of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** 2005 Elizabeth Lankford Parker January 20, 5:00 PM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Adams Low I.

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Deys Hours Min. Oct. 15, 1920 Buckinghams Choice Health Care Center Frederick 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M X(X)F 220-56-2732 84 Yrs. Mary land Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or frems 23s or 28s-4 show traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Frederick Adamstown Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3200 Bakers Circle 21710 U.S.A. Funeral permit. Pages 1 and 2 should be filed within 72 hours aftar death 1 Department of Health and Mantal Hygiene. Important: if Item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Madical Examinar mases Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Merried 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White 2 3 ☐ Widowed 4 ☑ Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Claude L. Lankford Blanche E. Meredith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Mrs. Elizabeth C. Bridgford, Daughter 112 North Court St., Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Resthaven Memorial Gardens Jan. 25, 205 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney and Basford PA Funeral Home 21. Signature of Funegal Service Licensee M00255 106 East Church St., Frederick, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequ Examine Type II DM eral Director: After this certificata has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 21/2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? TLI Yes 2 JONU 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? edicai Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 28a. Date of Injury (Month, Dey Yeer) 28b. Time of Injury 28c. Injury et Work? 27. Menner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifie 29c. License number 1-20-05 m00058762 aver mp 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 3000-D Ventrie Ct. Myersuille mo

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Y

istrer's Signature

			For	State of Marylan	d / Department of H		ental Hygier	۳ <u>5</u> 005	03811
			Registrar 1. Decedent's Name (First, Middle, Lasi	·)	Certificate of	Death	Reg. I	4 <u>6-</u>	3. Time of Death
	Physici /Medic			Williams	Pruitt			ay Year 05	535 PM
1	Examin	_	4a. Fecility Name (If not institution, give		me 1006 mg	r Location of Death		tc. County of Death	Jor
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. I	IULUIIUF	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea		place (State or Foreign
	Director		215-16-3204 10 Usual Residence of Decedent	M 200 F 00	Yrs. Northis Days	Hours Will.	01 20	1905 Vir	ginia
	yland how		10a. State 10b. County	- 4]	, Town or Location	11.			10d. Inside City Limits
	he Ma	ector	VA Accon	ruck Gr	eenbackvi	11e			1 ☐ Yes 2 ☐ No
	3a or 3	I D	10e. Street and Number 14510 Stock+	on Ave	10f. Zip Code	560	10g. (Citizen of What Cou	intry?
	tems 2	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	ican Indian, , etc.
036	d within 72 hours after death with the Maryland jiene. I than "natural", or Items 23a or 28a-f ahow the Medical Examinar must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1	1 ☐ Yes 2 🖫 No	Specify:		Specify: WI	tite
5-0	72 ho "natur	Completed	15. Decedent's Ed (Specify only highest grad		16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	ation during most of working	ng 16b.	Kind of Business/In	ndustry
2121	d within piene. r than *	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	Housewi			Domes	stic
pu	ild be filed fental Hyg rked other	Be	17. Father's Name (First, Middle, Last)	Dilliams		18. Mother's Name	(First, Middle, Maid	en Sumame)	<u> </u>
Maryland 21215-0036	d 2 should th and Mer 7 Is marke traumatic	ဥ	19a. Informant's Name/Relationship (7)		19b. Mailing Address (Street	and Number or Rura	Route Number, Cit	or Town, State, Zi	p Code)
	and 2 salth at n 27 is		Elinor Lee / Das	ughter	PO BOK 203	Keller.	VA a	3401	
Baltimore,	Pages 1 and nent of Healt int: If item 2 iry or other		20a. Method of Disposition 1 Burial 2 Cremation 3	Company of from Chata	lace of Disposition (Name of smetery, crematory or other place of CEME)	(a)		Location - City or T	- 1
altin	그 투 환 근		* 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service License		22. Name and Addre	ss of Facility			
ä	permi Depa Impo eny ic	0 1	James 71	. Fort				perancev	ille VA a 3442
	Per Contract		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.		ig, such as cardiac oi	r respiratory arrest,		Approximate Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)	a. TNEUMON Due to (or as a consequ					
	Examiner	_	Sequentially list conditions, if any leading to immediate	b. Cene Barva		euT.			
-	uted d ansit	miner	cause (Disease or injury that initiated events	C.	ionico di).				
90,	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	ıl Exami	resulting in death) Last	Due to (or as a consequ	rence of);				
68760	ficate be ex p physicien ts the burial	edica		d					
Вох	eath certific attending pl	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnal		,		23d. Date of delive	'
О.	at the dea by the at tached fo	Physiclan/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown				Month	Day Year
Ω.	res that the igned by be detact	by Ph	Part II. Other significent conditions co	_	llting in the underlying cause giv	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ord	w require been sig should b	sted	Chronic Ren	AL FAILURG			1 Tes		bably 4 □Unknown
of Vital Records,	The law ate has b page 2 s	ompleted	ATRIAL TOBA	ILLATION			24a. Was an autopsy performed?	prior to co	opsy findings available empletion of cause of
ital		BeC	25. Was case referred to medical examiner?			26. Place of Death	1 ☐ Yes 2 ☑ 1 (Check only one)	Vo 1 ☐ Yes	2 L No
of V	Phys this ral dir	ို	1 Yes 2 No	Hospital: 1 Inpatient 2 1	ER/Outpatient 3 DOA Oth	4 14 INUISING HON	ne 5 🗆 Residence 8d. Describe how in		(y)
ion	Attending Ph ir death. ector: After th by the funeral	atlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury Wor	k? Yes 2 □ No	3. 3330.130 11011 11.	jary oscariou	
Division	al or Attendir after death. I Director: Af d in by the fur	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory, office	2	8f. Location (Street City or Town, Sta	and Number or Run ite)	al Route Number,
	spits ours era fille	O			wledge, death occurred at the tir				
	To the Hos within 24 ho To the Fun completely	Medical	one)	iner: On the basis of examinat and manner stated.	ion and/or investigation, in my o				
	Veill Cor		29b. Signature and title of certifier	as & San	MD 29c. Licens	062172		Date signed (Month,	
، ا	Ţ		30. Name and address of person who o	ompleted cause of death (Item	23a) (Type, Print)				
H	,J		SHARAD (L SATY 31. Date filed (Month, Day, Year)	AL 1604 M 32. Signatian Signat	MAKET STREET	POLOMOKE	CITY MD	21851	•
	Sta Registi		JAN 2 5 2	005					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** David Kreigh Poole 25 6:15AM January 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Williamsport Washington Homewood retirement Center 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F Days Hours 78 Director May 22 1926 Maryland 220-18-2342 Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or items 23e or 28e-f ehov ther must be collified at 1 Yes X No Maryland Washington Hagerstown Direct 10e. Street and Number 10f. Zip Code 10g. Cifizen of What Country? 12917 Cathedral Ave. 21742 United States Funeral death 12. Was Decedent Ever in U.S. 13. Armed Forces?

1 ★ Yes 2 □ No 8/3/1944 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married 6/25/1946 Yes 2 No Specify: White ö 21215-0036 f Yes, Give Year or Dates: ð 3 Widowed 4 Divorced "netural" the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry n 27 is marked other then 's traumatic even. Elementary/Secondary (0-12) College (1-4or 5+) Attorney Law Firm Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fits Department of Health and Mental hy Important: If Item 27 is marked oth any injury or other traumatic event ADRE. Be David Kreigh Poole Lolita Bloom ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Zaiser Poole 12917 Cathedral Ave. Hagerstown Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 5 Other (Specify) Rose Hill Cemetery 1-28-2005 Hagerstown Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home eral Service License 21. Signatur 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fntervaf Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of defivery 3 Ectopic pregnancy ŏ in the pasf 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Dementia Arterial Fibrillation 24a. Was an autopsy performad? 1 ☐ Yes 2 ₺ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hypertension Hyperglycemia page 2 has certificate Pituitary Adenoma Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2X No this 28c. Injury at Work? 27. Manner of Death 1 XNatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No thours after death.

uneral Director: A

ly filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide in 24 hours.
the Funeral Directory filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifié and manner stated. within 2 To the I 29c. License number 296. Signature and title of certifie 29d. Date signed (Month, Day, Year) D26806 January 25, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen W Ditto 747 Northern Ave. Hagerstown Maryland 21742 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 28 Registrar

			Please	Type or State of								I Copies lental Hy		_	ble.		
						•	Cer	tificat	te of	Death			Reg. N	200)5	03	8 3
	1. Decede	nt's Neme (Fi	rst, Middle, La	st)								2. Dete of D Month		өу	Year	3. Tim	e of Death
Physician /Medical	lla	Ruth F	Parker									Januar		5, 20		7:	35 AM
Examiner	4a Facility	Name (If not	institution, giv	e street and nu	ımber)							cation of Dee	-	c. County			
0		ia Mand								Hager				ashir	ngton		
Funeral		ecurity Numb	1 1	ex □м 21 <u>X</u> ЛF	7. Age		est birthday) Yrs.	Months Months	r 1 Year Deys		24 Hrs. Min.	8. Date of B	lay, Yea	244	Count	17/	te or Foreign
Director		28-5125 idence of Dec		X		90	113.					May 22	2, 19	914	New Y	ork	
Jend Mand	10a. Stete		o. County		1	10c. City	, Town or Loc	cation							10	d. Insid	e City Limits
Mary Firsh	Maryl	and W	ashing	ton		Hage	erstown	ר								187	res 2□No
with the Mar	10e. Stree	t end Number						10f. Zi	Code				10g. C	itizen of V	Vhet Count	ry?	
filed within 72 hours efter death with the Maryland Hygiene. Hygiene, wither than "natural", or thems 23a or 28a-f show ent, the Medical Examiner must be notified at Completed by Funeral Director	12 Sc	outh Wa	Inut S	t. Apt	.703			2	21740	0				USA			
fler death v	11. Marital	Status		12. Was Dec Armed Fo	pedent Ev	er in U,	S. 13. V	Vas Dece Yes, spe	dent of I	Hispenic Original	gin? (Spe	ecify Yes or N Rican, etc.)	lo-		e - America k, White, e		٦,
or its		wer Married	_	1 ☐ Yes If Yes, Gi	2 (X)No ive					Specify:					Whit		
n 72 hours e "natural", o edical Exan		idowed 4 🗆		Year or D	Dates:		100 Doord	lant's Llou	al Osavi	netion			1ch		siness/Ind		
ed within 72 hoygiene. Ner than "naturi		(Specify o		de completed)			16e. Deced (Give i life. D	kind of wo	ork done ise retire	petion during most id)	t of work	ing	TOD.	KING OF BU	12111622/1110	ustry	
withi ene. than	Elemen	tery/Secondar G	y (0-12)	College ((1-4or 5+))	House						H	lome			
be filed tal Hyg d other event,	17. Fether	's Neme (Firs	t, Middle, Last))		'				18. Mothe	r's Name	First, Middle	e, Maide	n Sumam	θ)		
Menta Menta	Perl	ey Irv	in Macc	mber						Nell	ie L	indsey	Sta	rks			
shor and h		mant's Name/	Relationship (Туре, Pnint)			19b. Mailin	g Addres	s (Street	t and Numbe	er or Run	al Route Num	ber, City	or Town,	State, Zip	Code)	
and 2 path (Ruth	L. Sc	adden -	- daugh	ter		261 H			Ave.	Way	nesbor	o,PA	2176	58		
of He		od of Dispositi		Removal from	State	20b. Pl	ece of Dispos ern <i>etery</i> , crem	sition (Na natory or o	me of other pla	ice)	İ	Dete	20c.	Location -	City or Tov	wn, Stat	Ð
Peg ment ment: i			Other (Specif		· Otato	Smi	thsbur	_			- 1	- 27 - 05					and
permit. Peges 1 and 2 should be filed within Depertment of Heath end Mental Hygiene. Important: if item 27 is merked other than any injury or other traumatic event, tra Mannes. To Be Compi	21. Signat	ture of Funera	I Service Cice	6 99			22	. Name a	nd Addre	ess of Facility	y Osb	orne F	uner	al Ho	ome,P	.Α.	
00280	7	lang	NO.	lo-								St.		iams	port,	MD 2	21795
	23a. Part shoo	i. Enter the di ck, or heart fai	sease, or com lure. List only	plications that one cause on o	caused the	he death	. Do not ente	er the mo	de of dyi	ing, such as	cardiac	or respiratory	arrest,			Approxi Interval	mate Between and Death
Physician / /Medical	Immediate	e Cause (Fina		.10		10		0									
Examiner		r condition		· MZ	pira	MI	on	In	eu:	mon	100					46	dayo
				. ASP	D	ue to (oi	r es a conseq	uence of)	•						1	50	days segn
cian end cuniel-transit	Sequentia	Illy liet conditi	one C	b			es a conseq									-	fears
	if eny, lea cause. Er	ally list condition ding to immed nter Underlyin isease or injur	diate g														
_ ,	that initiet		5	C	Dı	ue to (or	as e consequ	uence of):									
entification plans and a second		,	L	d													
death certificate be settending physici d for use as the bu				J													
The law requires that the death certificate bate has been signed by the ettending physic page 2 should be deteched for use as the bate by Physiclan/Medica	Part II. Oth	ner significan	t conditions o	ontributing to d	death but	not resu	ilting in the ur	nderlying	cause gi	ven in Part I.							ise of death? 4∭Unknown
that the the the the the the the the the th												11	Yes	2□ No	3 □ Prob	асну	4 pg Unknown
uires the n signe												24a. Wa	s an aut	opsy	24b. We	re eutoj	sy findings
w rec												per	ioini o a :		con	npletion leath?	of cause
The law requir												10	Yes	a) No	1□	Yes	≱ Ó No
certificate rector, pag	25. Was c	ase referred t	o medical							26. Place	of Deat	h (Check only	one)				
Physic this ce el dire	1 🗆 Y				Inpatient		ER/Outpatien		UA			me 5□Re)	
ng Pi	27. Manne	er of Death aturel 5	☐ Pending	28e. Date (Mon	of Injury nth, Dey	Year)	28b. Time of Injury		28c. Inju Wo			28d. Describe	how in	jury occuri	red		
Attending Physician: or death, ector: After this certific by the funeral director, iffication: To Be (ccident	investigation Could not b					M		Yes 2 l		28f. Location	(Street	and Numb	or or Rum	l Route	Number
tal or Attending P rs efter death. al Director: After led in by the funers Certification:		omicide	determined	286. Place	ding, etc.	(Specify	me, farm, str	Bet, Tactor	y, omos			City or T	own, Sta	ite)	or or ribrar	710010	vanieor,
To the Hospital or Attending Physician: The I within 24 hours eiter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certi	fier 100	Certifying Ph	ysician: To the	e best of	mv knov	wledge, death	occurred	at the ti	ime, date en	d place,	and due to the	e cause	(s) and ma	nner as st	ated.	
he Hospit in 24 hour he Funer pletely fill	(Checone)	ck only 2	Medical Exam	niner: On the b	basis of e	xaminet	ion end/or inv	estigation	n, in my	opinion, dea	th occurr	ed at the time	, date a	nd place,	and due to	the cau	se(s)
To the within comp	29b. Signa	ature and title	of certifier	Ol as		1_		29		se number					d (Month, L		er)
48	1	Man	you (7-80	a	1.			1	283	365		- 1	- 2	6-07	-	
	30. Neme		. 0	completed cau	use of dea	th (Item	23e) (Type,	Print)		4	,				101	77 1	7 / 5
\	1 19	AN 2) SH	+1212 December 1	1 .	268 n	ull	S	reel	- /	+ag	evst	own	1/2	141	190
State Registrar	31. Dete f	iled (Month, D	N 2 7 2		Registrer	s signel	t. So	reste	,			Hag					

Neil Thomas Prendable

				artment of Health and Mental Hyg	giene 2005 03814
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month JANUARY	5
	/Medic	al	Neil Thomas Prendable 4a. Facility Name (If not institution, give street and number)		,
	Examin	er	6900 BLK. GREENBELT ROAD	4b. City, Town, or Location of Death GREENBELT	4c. County of Death PRINCE GEORGES
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,		
	Director		219-64-7109 1X M 2 F 48 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. March 2	
	p ,	}	Usual Residence of Decedent		
	shov	ž	10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits f XX Yes 2 ☐ No
	the M	ecto	MD Prince George's Greenbel		10g. Citizen of What Country?
	with be or	<u>=</u>			
	ns 20	Funeral Director	8116 Lakecrest Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20770 Was Decedent of Hispanic Origin? (Specify Yes or No-	USA 14. Race - American Indian,
9	after or Item	Fur	Armed Forces? 1 Yes 2 No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
93	72 hours after death with the Maryland natural", or Items 23e or 28a-f show lical Exercited hunt be notified at	d by	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2/1 ☐ No Specify:	Specify: White
Maryland 21215-0036	72 h natu	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
12	within ane. than	dmo	Elementary/Secondary (0-12) College (1-4or 5+)		MEMDO TRAMA
d 2	filed Hygie ther ant, the		17. Father's Name (First, Middle, Last)	ectronic Technician 18. Mother's Name (First, Middle,	METRO-WMATA Maiden Sumame)
an	ld be ental kad c	To Be	Jack Joseph Prendable	Ruth Lucile H	
ary	shou ind M i mar umat	! -		ing Address (Street and Number or Rural Route Numbe	
Ž	alth a alth a 27 ls		Ruth L. Prendable:Mother 9508	B Underwood Street, Lanhar	m, Maryland 20706
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Exercities must be rediffied at anone.		20a Method of Disposition 20b, Place of Dispo		20c. Location - City or Town, State
<u><u><u>ĕ</u></u></u>	Pag ment ant: I		_ / _ /	Litan Crematory 1/26/05	Alexandria, VA
Salt	Departs Departs Import any inj poce.			2. Name and Address of Facility ${\sf Gasch's}$ Fur	
_	20 E E O			39 Baltimore Avenue, Hyat	
П			23a. Part 1 Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respiratory an	rest, Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease of condition resulting in death)	んだう	Onset and Death
п	/Medical Examiner		Due to (or as a consequence of):		
ь		-e	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	uted d ansit	Examiner	Causa (Disease of Injury		
oʻ	an an rial-tr		resulting in death) Last C. Due to (or as a consequence of):		
8760,	death certificate be executed e attending physician and ind for use as the burial-transit	Physician/Medical	d.		
9	death certifica attending ph d for use as th	Med	IF FEMALE:		-
Вох	ath cattend	lan/	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy	23d. Date of delivery Month Day Year
o.	t the de by the a	ysic	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)	3.0
<u>α</u>	that the ed by detac		Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I. 23e. Did to	bacco use contribute to the cause of death?
Vital Records,	requiras that the een signed by th nould be detache	d by			es 2.XNo 3. Probably 4. Unknown
00	≥ .0 75	ete		24a. Was	an 24b. Were autopsy findings available
Re	The age	ompieted		autop	sy prior to completion of cause of death?
tal	sician: T certifical rector, p	e C	25. Was case referred to medical	26. Place of Death (Check only of	2 No 1 X Yes 2 No
Į N	S S	ToB	examiner? 1 XYes 2 No Hospital: 1 Inpatient 2 ER/Outpatie		ence 6 NOther (Specify) at scene
n of			27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injury at 28d. Describe h	ow injury occurred
Si	Attending r death. actor: After by the fune	atic	2 Accident investigation 1-22-35 14-20	PM 10 Yes 212 No PEDEST	110m struck by uslying
Division	l or Atten after deat Diractor; I in by the	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office 28f. Location (S	treet and Number or Rural Route Number, n, State)
	lospital or Al hours after of uneral Dirac sly filled in by	O	RODDWAY		AUDILLED GREENSSLTHD
	Hos Hor Hor Hor Hor	edicai	29a. Cartifier (Check only one) Certifying Physician: To the bast of my knowledge, deal (Check only one) Medical Examiner: On the basts of examination and/or in and manner stated.	th occurred at the time, date and place, and due to the c nvestigation, in my opinion, death occurred at the time, c	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the Hos within 24 ho To the Fun completely	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
1			Mouse The Moule	O.C.M.E.	ANUARY 23,2005
1	3/00	J.	30. Name and address of person who completed cause of death (Item 23a) (Type		
	200		Margarita Korell, M.D.	111 PENN STREET BALTIMO	RE, MARYLAND 21201
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature.		
1	Registr	ar	JAN 2 6 2003 Blane 1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No:--2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Jan. 23, 2005 2:50 P M Doris Geraldine Perry /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6908 Potomac Ave. Braddock Hgts. Frederick 8. Date of Birth Month, Day, Year May 4, 1925 5. Social Security Number 219-20-4889 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign County) 6. Sex **Funeral** Min Days Hours 1 □ M 2 😡 F 79 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County ral, or Itame 23s or 28s-f show Examiner must be notified at 1 Tyres 2 No MD Frederick Braddock Hgts. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21714 6908 Potomac St. USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White ģ 3√ Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) federal Elementary/Secondary (0-12) 12 College (1-4or 5+) government computer programmer and Mental Hygin permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy,
Important: If item Z7 Is marked other
any injury or other transmitted. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Stanley Haynes Mabel Marie Mullendore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Max Haynes (Brother) 211 E. Main St., Sharpsburg, MD 21782 20b. Place of Disposition (Name of commetery, crematory or other place) 1/26^D Pleasant View Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1/26705 1 Burial 2 Cremation 3 Removal from State Burkittsville, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Donald ddr B. Thompson Funeral Home 23a, art1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or art failure. List only one cause in each line.

Immediate Cause (Final disease are conditions) 31 E. Main St., Middletown, MD 21769 ReHensive Physician Year. disease or condition Due to (or as a consequence of) resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transi and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medlcai 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Wunknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25 No or Attending Physician: filled in by the funeral director. 25. Was case referred to medical 26. Place of Death | Check only one examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death after death. Injury 1 🗷 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide To the Hospital
within 24 hours a
To the Funeral Medical 23a. Curtiller _Cartifying Physiciam. To the best of my knowledge, death occurred at the time, date and place, and due to the cauco(s) and manner as stated. (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D3516 person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 6 2005 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2005 MARJORIE PTPER OUYNN anuary 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Washing Boonsboro Nursing tahrney Keedy ton If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🔀 F 383-34-9091 94 1910 MICHIGAN Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h Counts 1 ☐ Yes 2 No BOONSBORO MARYLAND WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21713 8507 MAPLEVILLE ROAD U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: 3 X Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ TEACHER PUBLIC SCHOOLS 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) AMBER NEELY WILLIAM PIPER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 94929 JANET C. FURBY/DAUGHTER P.O. BOX 241, DILLON BEACH, CA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2 XCremation 3 Removal from State 1 Rueint ' 4 ☐ Conation 5 Other (Specify) SMITHSBURG CREMATORY 01/26/2005 SMITHSBURG, MARYLAND 21. Signature of 5 22. Name and Address of Facility 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 21713 23a. Part 1. Enter the diseas Part1. Enter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): (or as a consequence of): Congestive (Heart Failure) Due to (or as a consequence of

Physician /Medical Examiner

burial-transi

the as attending

980

ρ

physicien

the 8

à

has page 2

certificate

this

After

Director:

within 24 hours a To the Funeral I

In by after

or Attending

death.

certificate be executed

Box 68760,

o

ے

Miston of Wial Records,

Physician

/Medical

Examiner

10a State

Director

Completed by Funeral

Be

2

Examiner

Physician/Medical

þ

Completed

Be

2

Certification:

Funeral

Director

item 27 is marked other than "natural", or iteme 23a or 28a-1 show other treumatic event, to Madical Examples fount be notified at

and Mental

t of Health

2121

and

Mary

Baltimore,

Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE 23b. Was decedent pregnant in the past 12 months?

9 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 3 Probably 4 Dinknown 24a. Was an autopsy performed

2 **□** No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner' 1 🗌 Yes 2 🗌 No

27. Mannes of Death

2 Accident

3 🗀 Suicide

4 Thomicide

1 Natural

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of Injury 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

1 ☐ Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a Certifier Medical (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified luna

6 Could not be

29c. License number D50362 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22911 Jefferson Blvd., Smithsburg, MD <u>Vincent A. Cantone,</u> M.D.

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

3H-2

			For State Registrar		State	of Mar	yland /		artmen rtificate			and M	lental Hy	giene Reg. No	200	5	03	817	
	Physicia	an	1. Decedent's Name (First,	Aiddle, Last									2, Date of De Month	Day		ar		ol Death	
	/Medic	al.	Thelma Ne 4a. Facility Name (If not inst	wcome:		charc	Ison		4h City	Town or	Location of	of Doath	Januar	_	2005 County of 0		10.5	OPM	
	Examin	er	13214 Founta						Hage			n Death			shing		Cour	nty	
	Funeral Director		5. Social Security Number 216-46-6155	6. Se	х]м 2[X F	7. Age (In yrs. last	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Nov • 27	th y, Year) 190.	9. 3 O	Birthp Coun hio	lace (State try)	e or Foreign	_
	and		Usual Residence of Decede 10a. State 10b. Co			1	0c. City, To	own or Lo	ocation							1	0d. Inside	City Limits	
	Maryl -1 sho	tor	Maryland Was	hinata	on Co.		Hager	rstov	vn								1 □ Ye	s 2 No	
	th the	lrec	10e. Street and Number						10f. Zip	Code				10g. Citiz	en of Wha	t Coun	itry?		_
	ath wi	ral	13214 Founta	inhead					217						S.A.				_
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23e or 28e-f show other treumetic event, the Medical Examiliar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ 3 ☑ Widowed 4 □ Div.		12. Was Der Armed F 1 Tes If Yes, G Year or	orces? 2 ⊠No live	er in U.S.		Was Deced If Yes, spec		ispanic Ori n, Mexicar Specify:	gin? (Sp i, Puerto	ecify Yes or No Rican, etc.)		4. Race - A Black, V Specify:		etc.		
9	2 hou	ted	15. Dec	edent's Edu	ucation		1	6a. Dece	dent's Usua	I Occupa	ation	t of work	ina	16b. Kir	nd of Busin				_
21215-0036	ad within 7 giene. er then "n , the Med	Completed	(Specify only (Elementary/Secondary (0 12	-12)		(1-4or 5+)		life.	kind of wor DO NOT us emaker	e retired)				sonal	Re	sider	nce	
pu	be filed Ital Hygi od other event, I	Be	17. Father's Name (First, Mi		.7.								e (First, Middle,	Maiden :	Sumame)				
Maryland	2 should be and Mental Is marked eumetic ev	ဥ	Charles Wil			er	1	I9b. Maili	na Address	(Street a			cGough al Route Numbe	er. City or	Town. Sta	te. Zio	Code)	_	_
	and 2 sealth an n 27 is		Philip W. Ri			on							Virgin				- 2	23451 La	
Baltimore,	es 1 an of Heal fitem 2 r other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Crema				20b. Place	of Dispo	osition (Nan	ne of			Date		ation - City				Ī
ii m	Pages tment of tant: If it tury or o		`4 □Donation 5 □ Oth	er (Specify))	Julio	Smith						1,2005	Smi	thsbu	rg,	Mary	land	
Bal	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Se			ry			2. Name an Dougla 1331 - I				uneral	Home erst	own.	Mar		2174	17
	Physician /Medical		23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	ie, or comp List only o	a.	BC	NE	(in respiratory as CLUR DPEN			4	Approxim Interval B Onset an	etween	
8760,	be executed ician and purial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	b. 12 Due to	O (or as a	Consequent consequent consequent	// <u>Ce of):</u>	WITI	4 /	PANC	CYTO	DPEN.	P					
.O. Box 68	death certific le attending p ad for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 □ Yes 2 □ No 9 □ Unknown	1		birth 2	pregnancy □Fetal deal	ath 3[□Ectopic pr □ Other (sp					2	3d. Date of Month		ery Day	Year	_
<u>α</u>	se ug	by	Part II. Other significant co	n ditions co	ontributing to	death but	not resultin	g in the u	inderlying c	ause give	en in Part I		23e. Did t		No 3	te to th		f death?]Unknown	
Vital Records,	The law ate has b page 2 sl	Completed											24a. Was autop perfo 1 Yes		deat	to cor	psy finding npletion of 2 No	s available cause of	
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to m examiner?	_	Hospital:					Othe	or		h (Check only o						_
of	Phys	: To	1 ☐ Yes 2 ☐ Ho 27. Manner of Death		1	Inpatient of Injury oth, Day Y		Outpatie b. Time c		8c. Injury	/ at	-	me 5 28d. Describe I			Specify	/)		-
ion	Attending Phradeng Phradens, After the funeral	atlor		ending vestigation	(Mo	nth, Day Y	'ear)	Injury	М	Worl	<br Yes 2□	No							
Division	or after in the	Certification:		could not be etermined	28e. Plac buil	e of Injury ding, etc.	· At home (Specify)	, larm, st	reet, lactory	, office			28I. Location (S City or Tox		Number o	r Rura	l Route Nu	ımber,	
	4 4 7 7 9 9 9 9 9	edical			iner: On the		kamination		vestigation	, in my op	pinion, dea		and due to the red at the time,	date and	place, and	due to	the cause		
	To the twithin 2 To the Complet	M	29b. Signature and title of c	ull	MD	Perso	ral !	Phys	Rcion	. License	number		4359	29d. Date	signed (M	Nonth, I	Day, Year)	2005	
1	H-15		30. Name and address of po	rson who c	completed car	use of dea ノルズ	th (Item 23	a) (Tylpe,	Print)	ÅU/S	: /	JAC.	ERST	ILIA	/ M	in	21	1742	
	Šta Registr		31. Date liled (Month, Day,	3 1 2(105	Registrar's	s Signature	9	milles	to be		,000	, , , , ,	-01	111		CA!	11	

			For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artment rtificate	of He	ealth a Death	and M		giene	005	5 (03818
			Decedent's Name (First, Middle	Last)					***		2. Date of De	ath	V-		3. Time of Death
ı	Physici /Medic		Clarence Edgar	Roy,Sr	•						Month Januar	Day V 26.	2005		10:30 A ^M
	Examin		4a. Facility Name (If not institution	give street and	(number)		4b. City, To	own, or l	Location o	f Death			County of D		
			Homewood Retir				Willi					Wa	shing		
	Funeral Director		5. Social Security Number 578-10-2863	6. Sex 1 X M 2□		. last birthday) Yrs.	If Under 1 Months	Days	Hours	Min.	8. Date of Bin (Month, Da Sept. 1.	th Year) 2,192	9. V i	Birthplac Country I rg I r	e (State or Foreign) nia
	pug M		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation					_		10d.	. Inside City Limits
	Aaryli F sho	ъ													1 ☐ Yes 2 No
	28a-	rect	Maryland Washi 10e. Street and Number	igron	VV	illiams	10f. Zip C	Code				10g. Citize	en of What	t Country	?
	3a or	Funeral Director	16505 Virginia	Ave. Co	ottage 5	4	21	1795					USA		
	ma 2	nera	11. Marital Status	12. Was [Decedent Ever in	U.S. 13.	Was Decede	nt of His	panic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	- 14	4. Race - A		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If Item 27 is marked other then "natural", or Itama 23a or 28a-f show any figury or other traumatic event, I'm Mardical Examination in Milled at Once.	by Fu	1 Never Married 2 Marri	ed 1 X Y	, Give 10	72	1 □ Yes 2		Specify:	, rueito	ricari, etc.)		Black, W	Vhite, etc hite	
21215-0036	hour tural'	q pa	3XXWidowed 4 □ Divorced 15. Decedent		or Dates:		dent's Usual	Occupat	ion				d of Busine		
7	in 72 n "na	Completed	(Specify only highes	grade complet		(Give	kind of work DO NOT use	done du	iring most	of worki	ng	TOD. IVIII	1 OI DUSING	5537111003	, , , , , , , , , , , , , , , , , , ,
7	with jiene.	m o	Elementary/Secondary (0-12) 5	Collec	је (1-4or 5+)	Glass	Glaze	er				Glas	s Mar	nufac	cturer
פַ	e filec Il Hyg othe vent,	Be C	17. Father's Name (First, Middle, I	ast)					18. Mothe	r's Name	(First, Middle,	Maiden S	u <i>mame)</i>		
Maryland	Menta Menta arkad	ToE	Clarence Edgar						Mabe			Mason			
lar	2 sh and is m	9	19a. Informant's Name/Relationsh								I Route Numbe				ode)
e,	1 and Health Sm 27 thar t		Tammy L. Collis 20a. Method of Disposition	- Gra.		Place of Dispo			Road		liker n		ation - City		. State
Jor	ages nt of l :: If It		1 ☐ Burial 2 X Cremation		om State	cemetery, crer	natory or oth	er place		07	0.5				
Baltimore,	artme artme ortani injury		' 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service		Sm	ithsbur	d Crei	Matc	of Facility	-21-	orne Fi	Smith	ISDUR	g,Ma	ry land ^
Ba	permi Depa tmpo any Ir		1 / 1 2	10											D 21795
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications th	at caused the dea									Ac	oproximate terval Between
	Physician		Immediate Cause (Final disease or condition	illy one cause	(910)	ic- H	Laxe	m	14					7	nset and Death
	/Medical		resulting in death)	a. Due	te (or as a conse	quence of).	499							14	11-12
	Examiner	_	Sequentially list conditions,	b	to or as a conse	WIP	<u>Γ</u>							16	May
	led nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	to (or as a conse	quence oi).									
	al-tra	хап	that initiated events resulting in death) Last	c	to (or as a conse	quence of):									
8760,	icate be executed physician and s the burial-transit	dicai		d											
9	tificat ng phy as th	ledi		1								1			
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant		, outcome of pregr ve birth 2 ☐ Fe		Ectopic preg	gnancy				23	d. Date of		w Your
<u>.</u>	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ P	regnant at time of nknown		Other (spec						Month	Da	y Year
P.O.	that the de ed by the detached	Phy	Part IL-Other significant condition	38 contributing	to death but not re	sulting in the w	nderlying cau	use diver	n in Part I		23e. Did to	obacco use	e contribut	e to the c	cause of death?
Vital Records,	signed d be del	d by	Court 6	MAHL	SOMA	HEU	71-	g			11	∕es 2□	No 3□] Probabl	y 4 Dunknown
200	w requir been si should	Completed	Der Land A. C	1676	on A.	1) 10	1247	4			24a. Was	an	24b. Were	autonsv	findings available
Re	he lav	dmo	Comme	Cae	,,,,,	VI	7	-7			autop perfo	rmed2	prior death	to compl	etion of cause of
a	lcian: The certificate ector, pag		25. Was case referred to medical						26 Place	of Death	1 Tes	2 No	1 🗆 Y	Yes 2L	No
	yalcia s cert direct	To Be	examiner?	Hospital:	☐ Inpatient 2[] ER/Outpatien	t 3 DOA	Other			ne 5 ☐ Resid		Other (S	Specify)	
10	g Physical this seral di		27. Marmer of Death	28a. D	ate of Injury Month, Day Year)	28b. Time of Injury		c. Injury Work	_/~		28d. Describe h			, ,,	
io	ttandin death. ctor: Aft / the fun	atio	1 Natural 5 Pending 2 Accident investig	ation	Norman, Day Today	injury	М		es 2 🗆 N	No					
Division of	I or Attanding I after death. Director: After I in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	and 288. P	lace of Injury - At I	home, farm, str	eet, factory,	office		1	28f. Location (5 City or Tox	Street and I vn. State)	Number or	r Rural Ro	oute Number,
	To the Hospital or Attanding Phyalcian: The within 24 hours after death. To the Funeral Director: Atter this certificate h completely filled in by the funeral director, page									1 -1					
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical		xeminer: On th	the best of my kr ne basis of examin nanner stated.										
	o the o the omple	Me	29b. Signatur are utility certifier	,)	x		29c.	License	number			29d. Date	signed (Mo	onth, Day	v, Year)
	18		DAY 11	MAN	((M 1)	latetti	1	T)(T	~		cla	12	, 200	0
	HTIVA		30. Name and address of person	completed	cause of death Vite	om 23a) (Type,	Print)	-ne	/	1.	Hu	برادسو/	The .	n /	w/
	Sta	to	31. Date filed (Month, Day, Year)	3	2. Registrar's Sign	nature	1/10	ult	w,	rive	- 1170	ayı	c	yu	XL U
	Registr	*	JAN 27	2005	Decem	1. A.	and the						20	42	

			1 - State Registrar	te of Maryland /		rtment of H tificate of L			eg. No. 00	5 03819
	Physicia		Decedent's Name (First, Middle, Last) DAVI	D EMILIO ROI	ORIGU	EZ		2. Date of Dea Month	Day Y	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street a Washington County Ho			4b. City, Town, or Hagers		ath	4c. County of	
	Funeral Director		5. Social Security Number 6. Sex 1 🖫 M 2	7. Age (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hi Hours Mil		1 9	D. Birthplace (State or Foreign Country) ennsylvania
	ъ		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loc	ation		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1001	10d. Inside City Limits
	Ba-f sho	ctor	Maryland Washington	Smith	ısbur	-				1 Yes 2 No
	h with th	al Dire	10e. Street and Number 14330 Pleasant Valley	Road		10f. Zip Code 21783	3	1	0g. Citizen of Wh	at Country? S • A •
336	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ita Maryland Examinar must be mained at ance.	by Funeral Director	1 Never Married 2 Married 1 If Y	s Decedent Ever in U.S. ned Forces?] Yes 2 1 No es, Give ar or Dates:	If	/as Decedent of Hi Yes, specify Cuba	spanic Origin? n, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)	Black,	American Indian, White, etc. White
21215-0036	within 72 ho ane. than natura	Completed	15. Decedent's Education (Specify only highest grade comp. Elementary/Secondary (0-12) Co		(Give k life. D	ent's Usual Occupa ind of work done of ONOT use retired	luring most of w	rorking	16b. Kind of Busi	·
nd 2	al Hygie d other i	Be Co	17. Father's Name (First, Middle, Last)					ame (First, Middle,		1
Maryland	should that marked umatic of	2	J. Luis Emilio Rodrig 19a. Informant's Name/Relationship (Type, Pri	_	9b. Mailing	Address (Street a	Ellen I	Pural Route Number	r, City or Town, St	ate, Zip Code)
	1 and 2 : Health ar em 27 Is ther trau		J. Luis Rodriguez (F			Pleasant	: Valley		nithsbur	, MD 21783
altimore,	Pages ment of H tant: If ite jury or of		1 ☑ Burial 2 ☐ Cremation 3 ☑ Remova 1 ☐ Donation 5 ☐ Other (Specify)	. ceme	tery, crem st Cei	atory or other place netery	1/2	27/05	Circlevil	lle, Ohio
Bal	permit. Departr Imports any inji		21. Sign v re of Funefal Service Licens	releef	RÖ.	Name and Addres BERT E. I 5 EAST MA	s of Facility DAILEY & LIN_STRE	SON FUNE	ERAL HOME	ES, P.A. 21788
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final	s that caused he death. D				ac or respiratory arr		Approximate Interval Between Onset and Death
	Prrysician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence	28 of :	- bome				
		iner	cause. Enter Underlying	Due to (or as a consequence	ce of):	00/4	4 4,561	-Cy		
ó,	cate be executed physician and the burial-transit	i Examiner	that initiated events c.	Due to (or as a consequence	oe of):					
68760,		edicai	d							
.O. Box	The law requires that the death certificate has been signed by the attending ragge 2 should be detached for use as	Physician/M	in the past 12 months?	es, outcome of pregnancy]Live birth 2		Ectopic pregnancy Other (specify)			23d. Date Month	
Δ.	uires that signed bi Id be deta	b	Part II. Other significant conditions contribution	ng to death but not resulting	g in the un	derlying cause give	en in Part I.			ute to the cause of death?
Vital Records,		Completed						24a. Was a autops perfor	med? prid	ore autopsy findings available or to completion of cause of ath?
Vita	Physician: The riths certilicate har all director, page	o Be	25. Was case referred to medical examiner? 1 🔀 Yes 2 🗀 No Hospita	l: 1 □ Inpatient 2 ☑ ER/	Outnations	3C DOA Othe		eath <i>(Check only or</i> Home 5 \square Reside		(Specify)
on of	Jing Atter tune	 	27. Manner of Death 1 Natural 5 Pending		D. Time of Injury	28c. Injury Work			ow injury occurred	
Division	Hospital or Attending 24 hours after death. Funeral Director: Atte tely tilled in by the tune	ertification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	. Place of Injury - At home, building, etc. (Specify)	, farm, stre		20.00	28f. Location (S. City or Town		or Rural Route Number,
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely tilled in by the	edical Co	29a. Certifier 1 Certifying Physician: (Check only one) 1 Medical Examine: 0 ar	n the basis of examination	and/or inv	estigation, in my or	oinion, death oc	curred at the time, d	ate and place, an	d due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	7:40 mm	5	29c. License	1062	2	9d. Date signed (Month, Day, Year)
	9		30. Name and address of person who complete	ed cause of death (Item 23	a) (Type,)	Print) 2/24	16	Silwof W.	Ditto D	(4)
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 4 2005	od cause of death (Item 23.	16	forts	,(')	11 146		

Amend item state of Marylan 89 begaring of Health and Mental Hygien 0 0 5 03820 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 26, 2005 JAMES JOSEPH ROWAN JAN. 6:56 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner EGLE NURSING AND REHAB CENTER LONACONING ALLEGANY 8. Date of Birth (Month, Day, Year)
JAN. 1, 1923 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MARYLAND **Funeral** Days 1 💢 M 2 🗆 F Months Hours Director 215-16-4175 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at MD ALLEGANY LONACONING No Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 57 JACKSON STREET 21539 USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 [XYes 2 □ No4/8/43 If Yes, Give Year or Dates: 12/18/45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Exempter. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: <u>≨</u> Specify: WHITE 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) QUALITY CONTROL PAPER INSPECT. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WINIFRED J. ROWAN NINA SLUSS ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. M215/14 SCECCERS Tyles DEvial ROSW, with Wester Emport 27 MD. 21562 KATHERINE A. JAMES 6121 PLAINVILLE LN, DALE CITY, VA 22193 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SUNSET MEMORIAL 1/29/05 CUMBERLAND, MD 4 Donatio 5 Other (Specify) Fuçeral Se Co Licensee 22. Name and Address of Facility SHAFFER-WARNICK FUNERAL HOME 21. Signati 230 E. MAIN ST., ROMNEY, WV
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. **Physician** Preumonia, bacterial Immediate Cause (Final disease or condition resulting in death) /Medical 1 week Examiner Due to (or as a consequence of):

mall Cell Carcinoma of Lung Examiner 3 manths or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) resulting in death) Last Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? Chronic obstructive pulmonary disease 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown δ 24b. Were autopsy findings available prior to completion of cause of death? Completed Dementia of Alzheiner Type 24a. Was an autopsy performed? 1 Tes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗆 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 20 Douglas Ave., Longeoring, md. J. Deulin

32. Eggistrar's Signature

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

2005

			1 - For State Registrar	State of M	Maryland		artment of H		d Mental Hyg	iene 005	03821
	Physici	an	Decedent's Name (First, Midd	lle, Last)					2. Date of Deat Month	_	3. Time of Death
	/Media	al	Marie H. 4a. Facility Name (If not institution	on give street and number		hockle	4b. City, Town, or	Location of D	January	24, 2005 4c. County of E	
	Examir	ier	1004 Riverhous				Salisbu		Julii .	Wicom	
	Funeral Director		5. Social Security Number 219-07-7284		Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 h	lin. (Month, Day,		Birthplace (State or Foreign Country) Delaware
	and w		Usual Residence of Decedent 10a. State 10b. County	,	10c. City	. Town or Lo	cation				10d. tnside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-1 show any injury or other traumatic event, ite Medical Ever in artifical at anone.	Funeral Director	Maryland Wico		Sal	isbury				On Ciainan of Min	1 \ Yes 2 □ No
	with t	ā	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wha	it Country?
	death	nera	1004 Riverhous 11. Marital Status	12. Was Decede	nt Ever in U.S	S. 13.	2180 Was Decedent of H	Ispanic Origin?	(Specify Yes or No- lerto Rican, etc.)		American Indian,
21215-0036	urs after al', or Ite	Ď	1 ☐ Never Married 2 ☐ Mar 3 💢 Widowed 4 ☐ Divorced	If Yes, Give *	No		1 Tes, speciny Cuba 1 ☐ Yes 2 🔀 No	Specity:	ieno rican, etc.)	Specify:	White, etc. White
20	72 ho	Completed		nt's Education est grade completed)		(Give	dent's Usual Occupa	during most of	working	16b. Kind of Busin	
121	within ne. .han "	mpl	Elementary/Secondary (0-12)	Cotlege (1-4d	or 5+)		DO NOT use retired)			
р В	filed v Hygie other t	CO	12 17. Father's Name (First, Middle,	, Last)		HC	memaker	18. Mother's I	Name (First, Middle, M		estic
au	ild be lental rked o	To Be	Franklin			Hobb	ng .	Lena		BO	stic
Maryland	2 should and Men is marke aumatic		19a. Informant's Name/Relations	ship (Type, Print)					Rural Route Number,		
	and 2 ealth m 27 i		Patty S. Twill 20a. Method of Disposition	ey (daughte	er)	P. O.	Box 9534	121, La	ke Mary, F	lorida :	32795
Baltimore,	Pages 1 nent of H int: If iter iry or oth		1 Burial 2 Cremation	3 Removal from Sta		ace of Dispo	natory or other plac	e)	Date	20c. Location - City	y or Town, State
量	artmer artmer ortant injury		'4 □ Donation 5 □ Other (S		Sal	1.23	Cremator	s of Facility	- D		ry, Maryland
Ba	permit. Departr Imports eny inj	I	to su.	1-kellon	_	H	Clloway E	Tuneral	Home Prof ad, Salisb	essional	Association yland 21804
			23a Part. Enter the disease, o	r complications that caus t only one cause on each	sed the dea h						Approximate Interval Between
	Pnysician:		tmmediate Cause (Final disease or condition	Plea	1	Ffus.	àn an				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	as a consequ						
		-	Sequentially list conditions,	b. Due to (or a	as a consequ	ence of):					
	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying are that initiated events	S. Co	nces tiv	10.00	err Falu	(1)			Sales and the sales are sales and the sales ar
ó	be executed siclan and burial-transit	Exa	resulting in death) Last	Due to (or a	as a consequ						
8760,	icate be ex physician s the buria	dical		d							
9	eath certific attending pl	/Mec	tF FEMALE:	23c. tf yes, outcon	ne of pregnar	ncv				22d Date of	dollara
Box	death death death death death	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant	2 ☐ Fetat at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	Day Year
О	that the de ed by the a detached f	hys	9 🗌 Unknown	9□ Unknown							
rds,	sign sign d be	ρ	Part II. Other significant conditi	ons contributing to death	but not resu	iting in the ui	nderlying cause give	en in Part I.			te to the cause of death? Probably 4 Unknown
Records,	sician: The law requ s certificate has been lirector, page 2 shoul	Completed							24a. Was ar autopsy perform	prior deat	e autopsy findings available to completion of cause of h?
Viital	. a c	a	25. Was case referred to medica	al			<u>-</u> -	26. Place of [1 ☐ Yes 2 Death (Check only one		Yes 2□ No
	Physici this cer al direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🗀 Inpa	itient 2 🗆 E	ER/Outpatien	t 3 DOA Othe	20	Home 5 Reside		Specify)
o uo	ding I		27. Manner of Death 1 Natural 5 □ Pendi	28a. Date of Ir (Month, L igation	njury Day Year)	28b. Time of Injury	Work	vat ⟨? Yes 2 □ No	28d. Describe ho	w injury occurred	
Division of	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Certification:	2 Accident Invest 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of t	tnjury - At hor etc. (Specify)	me, farm, str	eet, factory, office		28f. Location (Str City or Town		r Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in the Funeral or the Funeral Director of t		29a. Certifier 1 Continuit	ng Physician. To the ba	st of my know	viedge, deatt	occurred at the time	re, date and pla	ice, and due to the ca	use(s) and mannel	r as stated.
	vithin 24 To the Fi	Medical	one)	Examiner: On the basis and manner	stated.	on and/or in					
	or Too		29b. Signature and title of certifie	ar T			29c. License	i i i i i i i i i i i i i i i i i i i	25	d. Date signed (M	1. Day, rear)
,	De.		ame and ad ress person	who completed cause of	f death (Item	23a) (Tune	Print)	77 06 1,	7	1/25	105
	20	4	were he	JARRAH	MO	. 12		berto	DR. Sal	isbury,	MD 21801
**	Sta Registr		31. Date filed (Month, Day, Year, JAN 2	6 2005 32. Re	strar's Signati	J. A	borte			, ,	

			For	State of Ma		d / Depa	artment of H	lealth a	and Mer	•	ene On o s	00000
			State Registrar			Cei	tificate of	Death			g. No. UUD	03822
	Physici	an	Decedent's Name (First, Middle, La		-					Date of Death Month	Day Yea	
	/Medic	al	DONALD MONROE 4a. Facility Name (If not institution, give	SCHWARTZ	JR.		4b. City, Town, o	r Location o		ANUARY	29 2005 4c. County of De	Z:55 A
	Examin	er	20051B DOG STREET					DYSVII				INGTON
Ī	Funeral		5. Social Security Number 6. S	Sex 7. Ag		last birthday)	If Under 1 Year Months Days	If Under :	24 Hrs. 8.	Date of Birth (Month, Day,	(ear) 9. B	irthplace (State or Foreign Country)
	Director		217-60-2272	1 🔯 M 2 🗆 F	_53	Yrs.			DE	C. 11,	1951 I	1ARÝLAND
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Many a-f sh	ţō	MARYLAND WASHI	NGTON				KEJ	EDYSVI	LLE		1 ☐ Yes 2X No
	th the or 284	Director	10e. Street and Number		•		10f. Zip Code			10	g. Citizen of What	Country?
	ath w	rai	20051B DOG STREE	1 "					756			S.A.
	items	nue	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔀		.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Orig an, Mexican	gin? (Specify n, Puerto Rica	y Yes or No- an, etc.)	14. Race - Ar Black, Wi	nerican Indian, nite, etc.
920	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	10		1☐ Yes 2፟X No	Specify:			Specify:	WHITE
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Modeal Examiner must be mailfied at	Completed by Funeral	15. Decedent's E (Specify only highest gr			16a. Dece	dent's Usual Occup	ation during most	t of working	10	6b. Kind of Busines	s/Industry
2	within ene.	ğ	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. i	DO NDT use retired	d)			CTATE CO	\\\T\\\T\\\T\\\\\\\\\\\\\\\\\\\\\\\\\\
	filed v Hygie other t	e Co	17. Father's Name (First, Middle, Last			E	XTENSION			irst, Middle, Ma	STATE GO	A EMINITENT
lan	should be nd Mental marked o	To Be	DONALD MONROE SCH					ANNA				
Maryland	and M s mar		19a. Informant's Name/Relationship	Type, Print)		19b. Mailir	ng Address (Street	and Numbe	er or Rural Ro	oute Number,	City or Town, State	, Zip Code)
Σ.	and 2 ealth a n 27 i		DENISE M. SCHWART	Z/SPOUSE	1			REET I				RYLAND 21756
Baltimore,	ges 1 if itel or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐		0	emetery, crer	sition (Name of natory or other plac	·	Date	-	oc. Location - City o	
Itim	it. Pa urtmen irtant: njury		' 4 □ Donation 5 □ Other (Special Service Line 21. Signature of Faneral Service Line 21.	-	SM						MITHSBUR National	G, MARYLAND
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic en		De amonda	Paul N	1. De	an BA	ST FUNER	AL HON	ME BO		, Maryla	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on each li	the deat	h. Do not ent	er the mode of dyir	ng, such as			, ,	Approximate Interval Between
ı	Physician	0 1	Immediate Cause (Final disease or condition	7	72.0 =		Canear					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a cons-q		The state of the s					
	Lxammer	<u>.</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a conseq	uence of):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		,							
oʻ	be executed sician and burial-transit	Еха	resulting in death) Last	Due to (or as	a conseq	uence of):						
3760,	a × a	licai	•	_ d								1
x 68	w requires that the death certifica been signed by the attending ph should be detached for use as th	by Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregna	incv		00000000			22d Date of d	olivon
Вох	atten atten	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐Live birth 4 ☐ Pregnant at	2 Feta	Ideath 3□	Ectopic pregnancy Other (specify)	/			23d. Date of d Month	Day Year
P.O.	t the d by the	hysi	9 Unknown	9□ Unknown								
	es tha gned be det	by P	Part II. Other significant conditions	contributing to death b	ut not res	ulting in the u	nderlying cause giv	en in Part I.				to the cause of death?
ord	requir een si nould									1 □ Yes	2 121√10 3 🗆 1	Probably 4 Unknown
Sec.	: The law requires that the cate has been signed by the page 2 should be detache	Completed								24a. Was an autopsy performe	prior to	autopsy findings available completion of cause of
Division of Vital Records,			OS Mas area referred to medical					68 Di		1 Yes 2 (⊒476 1□Ye	
<u>=</u>	Attending Physician: r death. ector: After this certific. by the funeral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 🗆	ER/Outpatien	t 3 DOA Oth			theck only one; 5 Residen	ce 6 □Other (Sp	pecify)
סר	ig Phy ter thi		27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time of Injury					injury occurred	,
Siol	eath. or: Af	catic	2 Accident investigation	n			M 1 🗆	Yes 2 □ I				
Σİ	or Atl	Certification:	3 Suicide 6 Could not to determined	28e. Place of Inj building, et	ury - At ho c. <i>(Specif</i>	ome, farm, str y)	eet, factory, office		28f.	City or Town,		Rural Route Number,
	Hospital or 24 hours afte Funeral Dir stely filled in		29a. Certifier 1 ☐ Certifying P	hysician: To the best	of my kno	wledge, death	occurred at the tir	me, date an	d place, and	due to the cau	se(s) and manner	as stated.
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	(Check only 2 Medical Exa	miner: On the basis o and manner st	f examina	tion and/or in	vestigation, in my o	pinion, deal	th occurred a	at the time, dat	e and place, and di	ue to the cause(s)
	To the I within 2 To the I complet	Σ	29b. Signature and title of certifier	1 0			29c. Licens	se number		290	d. Date signed (Mo	nth, Day, Year)
			" muchael f	. Mular	mul	- MO	2 0	4166	:7		1 . 3/-	05
كلا	H-15			Completed cause of c	leath (Item	1 23a) (Type,	Print) Wedical	(a.	mpu	, the	d. Date signed (Mo.	mo.
	Sta Registr	_	31. Date filed (Month, Day, Year) JAN 3 1 2	2005 Augustr	ai s signa	B. Sp	etel					

			State of Maryland		artment of H		Mental	Hygier	2005	03823
			Registrar 1. Decedent's Name (First, Middle, Last)		timodito or	Dodin		of Death		3. Time of Death
	Physici		FRANCES LUCILLE	SCH	NEBLY		Janua	arv 26	2005 Year	315 PM
	/Medio Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of De			tc. County of Dea	th
1	EXCITION		16505 Virginia Avenue		Willi	amspor			Washin	gton
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 H Hours M	rs. 8. Date	of Birth oth, Day, Yea		thplace (State or Foreign ountry)
	Director		212-38-7883 ^{1□M} ¾□F 86	Yrs.						Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, T	own or Lo	cation			-		10d. Inside City Limits
	Manyl 4 sho	ō	Maryland Washington W:	illi	amsport					1 ☐ Yes 2 ☐ No
	with the Maryland a or 28a-f show	rec	10e. Street and Number		10f. Zip Code			10g. (Citizen of What Co	ountry?
	23a o	Funeral Director	16505 Virginia Avenue		2179	5			U.S.A	
	after death w or itams 23a	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of H	lispanic Origin? an, Mexican, Pu	(Specify Yes erto Rican, e	or No-	14. Race - Ame Black, Whit	
36		by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No yz If Yes, Give		1 ☐ Yes 💥 ☐ No	Specify:			Specify:	White
21215-0036	72 hours "natural",	g pa		6a Dece	dent's Usual Occur	nation		16b.	Kind of Business	
15	<u> </u>	Completed	(Specify only highest grade completed)	(Give	kind of work done DO NOT use retire	during most of v d)	vorking	133.	,	,
212	y with	mo	Elementary/Secondary (0-12) College (1-4or 5+)	Sch	ool Tea	cher		Pι	blic S	chools
pu	be filed with tal Hygiene. Id other than event, the N	Be C	17. Father's Name (First, Middle, Last)			18. Mother's N	lam <i>e (First, I</i>	viiddle, Maide	en Sumame)	
<u>la</u>	Mental Mental arked c	10 6	9	shwa		Julia		Came		Seibert
Maryland	s 1 and 2 should be filed v if Health and Mental Hygie item 27 te marked other t other traumatic event, III				ng Address (Street					
	s 1 and if Health item 27 other tr		John L. Schnebly Son 20b. Place		East Oak	Prage D	Date		Location - City or	
آور	ages if its		1 Burial 2 Cremation 3 Removal from State	etery, crer	natory or other pla				•	wn, Maryland
Baltimore,	permit. Pages Department of Important: If i any injury or one	}	`4 □Donation 5 □Other (Specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □							
Ba	permit. F Departme Importan any injur		& R. hoel Brady		Andrew Art. 10 Fast A	LOIIMA Antietam	n Fune	tal Ho	ome, inc	. Md. 21740
			23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause propach line.						Jerscomii	Approximate Interval Between
	Physician		Immediate Cause (Final		1. F +	tre b	12016	+		Onset and Death
7	/Medical		disease or condition resulting in death) Due to (or as a consequen		0.7	ce p	1 6.67 -3			One ocen
	Examiner		Sequentially list conditions.							
	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ce of):						
	be executed iician and burial-transit	xam	that initiated events resulting in death) Last C. Due to (or as a consequent)	ice of):						
8760,	ate be execul physician and the burial-trar			,						
687	ficate p phys is the	edical	d							
Вох	leath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal de		Ectopic pregnanc				23d. Date of de	*
	0 0 0	icia	in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death		Other (specify)	у			Month	Day Year
P.0	ac ac	hys	9 Unknown					5111		
	es page	þ	Part II. Other significant conditions contributing to death but not resulting	ig in the ui	nderlying cause giv	∕en in Paπ I.	230		1	o the cause of death?
orc	w requires been sign should be	eted	- ENIPHY SE MIC				-			
Records,	es sc	Completed					- 24a	. Was an autopsy performed?	prior to	utopsy findings available completion of cause of
	Th ate pag							Yes 2		2 No
V.		o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER	VOutpatier	nt 3 DOA Ott	26. Place of D		Residence	6 □Other (Spe	orfu)
of		n: To	27. Manner of Death 28a. Date of Injury 28	Bb. Time of					jury occurred	ony)
ion	Attanding Products of the function of the functions of th	atio	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury		Yes 2 No				
Division of Vital	r Atta er de racto	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office			ation (Street or Town, Sta		ural Route Number,
0	ital o rrs aft ral Di	Se								
	To the Hospital or Attandi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu	edicai	29a. Certifier (Check only one) 29 Medical Examiner: On the basis of my knowle and manner stated.							
	the the the the the the the the the the	Med	29b. Signature and title of certifier		29c. Licens	se number		29d. E	Date signed (Mont	th, Day, Year)
	۵ ≒۶ ≒			DM	D D	17591		-	Maranson.	77 7005
			30. Name and address of person who completed cause of death (Item 23	3a) (Type,	Print)	011		اعدا	wary.	I Jaco
0	5H-10		George Mewman # MD IIIO Me	dical	Print) Compus	Rd Ste	130 Ha	gerston	un, MD:	21742
	Sta		31. Date filed Month, Pay, Year) 32. Registrar's Signature	9	1			J		
	Registr	ar	JAN & O LOUD Solver B	15	redel					

			1- For State of Maryland / Dep	partment of F ertificate of			ene g. No. 005	03824
	Physici /Medic		Decedent's Name (First, Middle, Last) George W. Simms			2. Date of Death Month January	20, 2005	3. Time of Death 12:35p ^M
	Examin	er	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Silver	Spring If Under 24 Hrs.	8. Date of Birth	4c. County of Deat Montgome:	ry
	Funeral Director		579-07-7500 10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Months Days	Hours Min.	Aug. 15,	1916 Eri	hplace (State or Foreign untry) e, Pa.
	the Marylar 28a-f show	Director	10a. State 10b. County 10c. City, Town or Maryland Montgomery Silver	Spring 10f. Zip Code		10	g. Citizen of What Co	10d. Inside City Limits 1 XYes 2 No
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural, or items 23e or 28e-1 show importent: If item 27 is marked other then "natural, or items 23e or 28e-1 show any figury or other treumatic event, the Mexical Examinational Landscape on 2000.	by Funeral Dir	8600 16th Street	2091(3. Was Decedent of Hir Yes, specify Cuba 1 Yes 2 No		Ţ	United Sta 14. Race - Ame Black, White Specify: B1	tes ncan Indian, e, etc.
Maryland 21215-0036	d within 72 hor giene, er then "natura i the Medical E	Completed	(Specify only highest grade completed) (Gillerentary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occup ve kind of work done i. DO NOT use retired Orter	vation during most of work d)	ing	6b. Kind of Business/	Industry
yland	ould be file d Mental Hy narked othe natic event,	To Be C	17. Father's Name (First, Middle, Last) Charles Simms	· · · · · · · · · · · · · · · · · · ·	Sadie	e (First, Middle, M Quarles		
, Mai	and 2 sh balth and a 27 Is n er treun		19a. Informant's Name/Relationship (Type, Print) Gary W. Simms / Son 484	-	ve. Hyatt		City or Town, State, 2 Md. 20784	
altimore,	Pages 1 Iment of He tent: If Iten jury or oth		1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, co	position (Name of rematory or other place d Nationa	1 Jan.2		oc. Location - City or aurel, Md.	Town, State
Bal	Deparit Deparit Impor any in		21. Signature of Funeral Service Ligensee	22. Name and Addre Alexander 5538 Mari	ss of Facility S. Pope	Funeral e/Forestv	Homes, Md.	A·20747
	Prysician		23a. Part 1. Enjer the disease or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Respiratory Fai resulting in death)	_	ig, such as cardiac	or respiratory arre:		Approximate Interval Between Onset and Death WKS
	/Medical Examiner		Sequentially list conditions Due to (or as a consequence of): Pneumonia					l month
8760,	icate be executed physician and s the burial-transit	dical Examiner	fl ary, leading to uninediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Chronic Obstruc Due to (or as a consequence of):	tive Pulmo	onary Dise	ease		
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med		3 □Ectopic pregnancy 5 □ Other (specify) _	(23d. Date of deli Month	very Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the Congestive Heart Failure	underlying cause giv	en in Part I.		acco use contribute to s 2 □ No 3 ②Pr	the cause of death?
al Records,		Completed	Hematuria			24a. Was an autopsy perform 1 Yes 2	prior to d	topsy findings available completion of cause of
f Vital	Physician: The this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 1 No Hospital: 1 Inpatient 2 ☐ EP/Outpate	rent 3 DOA Oth		h <i>(Check only one</i> ome 5 Resider) nce 6 □Other (Spec	cify)
Division of	ing i	Certification;	27. Manner of Death 1 Notatural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be	/ Wor M 1□	rk? Yes 2 □ No	28d. Describe how		
N	spitel or Attend ours after death lerel Director; /		4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospitel within 24 hours a Vo the Funerel Completely filled	ledical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my o	pinion, death occurr	and due to the cau red at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 Complet	Σ	29b. Signature and title of certifier	29c. Licens			d. Date signed (Monti	. /
	SC		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print) evry to Aver	101 Si	luer Spri	many 21;	72
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	, ,			/	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Edward Smith January 23. 2005 5:20 P.M. /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Mariner Health Care at Circle Manor Kensington Montgomery If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthdey) 5. Social Security Number 6. Sex **Funeral** 1√2 M 2□ F Months Deys 73 Director 426-36-7272 Usuel Residence of Decedent 2/8/31 Jackson, Miss filed within 72 hours aftar death with the Maryland Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylar Depentment of Health and Mantal Hygiene. Important: If Item 27 is marked other than "naturel; or itema 23e or 28e-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Md. Montgomery Takoma Park 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 1208 Holton Lane 20912 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondary (0-12) 12th Insurance Insurance Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be P Tillie Terry

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Edward Smith 19a. Informant's Name/Relationship (Type, Print) Donna Calcote/Niece 1815 Manorfield Ct., Mitchellville, Md. 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 1/28/05 Harmony Mem. Park Landover, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 any w 1.1 411 expesse, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory errest, feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final 2 weeks disease or condition resulting in death))orchair Examiner Due to (or as a consequence of): Physician/Medical Examiner the attanding physician and ched for usa as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or es e consequence of): resulting in death) Lest Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? page 2 should be datached 2 No 3 Probably 4 Unknown 1 Yes been signed by 2 24a. Was en autopsy performed? 24b. Were autopsy findings aveilable prior to completion of cause of deeth? Completed certificata has 2,000 No 1 ☐ Yes 2 ☐ No 1 🗆 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. Be 25. Wes cese referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient Other: edicai Certification: To 1 ☐ Yes 2 ☐ No 2 ER/Outpetient 3 DOA AD Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier ##Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 900 Som DO0 53556 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 Keeld Kerce 2309 elleaton 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State JAN ∠ 6 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician Year enniter Januar 0,000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Doctors Community Hospital Lanham Md. Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F 578-64-4092 Wash., D.C. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show event, the Madical Exeminer must be notified at Md. P.G. New Carrollton 1 □ Yes 2 □ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7804 Powhatan St. 20784 U.S.A. or items 23a 12, Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) Assistant
Administrative Audiology 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than "any injury or other traumatic event, Ite Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Hospital 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William Jones Loretta Burgess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son Anthony W. Vieira Son Domitria Viera-Daughter 1900 Waesche Place Bowie Maryland 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Resurrection 1 Durial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Jan. 29,05 Clinton, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 2. Name and Address of Facility Washington, D.C. Robinson Funeral Home 1313 6th 20001 St.N.W. 23a. Part1. Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ナん /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Ten Due to (or si consequence of): The law requires that the death certificate be executed physician and s the burial-transit Tich ster Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No 1 Inpatient 2 To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗀 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar completed cause of death (Item 23a) (Type, Pnnt)

32. Re

			1- For State of Maryland / Department of Health and Mental Certificate of Death	Hygiei Reg.	GUUD	0382	7
	Physici	an	An Mon		Day Year	3. Time of	
	/Medic Examir		al		20 2005 4c. County of Death FREDERICE		РМ
	Funeral Director		5. Social Security Number 220-48-8293 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Nov	of Birth oth, Day Ye 7 • 12	9. Birth 25 Co.	place (State or intry) reece	Foreign
	nyland how		10a. State 10b. County 10c. City, Town or Location			10d. Inside Cit	y Lîmits
	the Ma 28e-f s	ecto	MD Frederick Frederick 10e. Street and Number 10f. Zip Code			1 🗌 Yes	2 X No
	3e or	a Dir	10e. Street and Number 10f. Zip Code 4820 Hargett Lane 21702	10g.	Citizen of What Cou	intry?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neturel", or items 23e or 28e-f show amy injury or other treumatic event. It a Madical Exacting must be notified at anone.	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rican, et or or Dates:	or No-	14. Race - Amer Black, White Specify: W		
Maryland 21215-0036	72 hour	ted k	Teal of Dates. 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working	16b	. Kind of Business/li		
121	within and the second	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Cigive kind of work done during most of working life. DO NOT use retired) homemaker				
ک امر	ould be filed v Mental Hygie varked other t	Be Co	u 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, M	Middle, Maid		9	
ylar	should by	To E	P Ryllakos valvalessos Hatilua ka				
Mar	and 2 sh ealth and n 27 is rr		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route II 19c. Thomas Stone (Husband) 4820 Hargett Ln, Fred	_{Vumber, Cit} leric	ty or Town, State, Zi ${f k}$, ${f MD}$ 2	p Code) 21702	
altimore,	es 1 ar of Hea of Hea of Item or other		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	20c.	. Location - City or T		
Ē	it, Pages rtment of h rtent: If ite njury or of		`4 □ ponation 5 □ Ottran (Specify) Frederick Crematory 1/24/	-		·	
Ba	permit, Departr Importe any inji		21. Skinatur of Fineral Servit Licensee Bonand Address of Trillompson 31 E. Main St., Mid	Fune:	ral Home	21769	
-	Prrysician /Medical Examiner		29a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiral shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as 1 onsequence of):	tory arrest,		Approximate Interval Betw Onset and D	reen
8760,	vate be executed hysician and the burial-transit	dical Examiner					
.O. Box 68	ath certific ittending p or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown		23d. Date of deliv	_	ear .
ecords, P.	w requires that the de been signed by the a should be detached f	by	236.	Did tobacc	co use contribute to	he cause of de bably 4 🗆 Ur	
		Completed	on privious embolic strotte	Was an autopsy performed?	? death?	opsy findings av impletion of cau	/ailable use of
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				
Division of	To the Hospitel or Attending Physician: within 24 hours after death to the Funeral Director: After this certific completely filled in by the funeral director,	atlon; To	1 Inpatient SER/Outpatient 3 DOA 4 Nursing Home 5		o 6 ⊡Other (Special	(y)	
Divis	tel or Atters after de al Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	tion (Street or Town, Sta	and Number or Run ate)	al Route Numbe	∋ <i>r</i> ,
	To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical	29a. Certifier (Check only one) 29a. Certifier (Check only one) 4 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the death occurred at the time, date and place, and due to the death occurred at the time, date and place, and due to the death occurred at the date and place, and due to the death occurred at the time, date and place, and due to the death occurred at the time, date and place, and due to the death occurred at the time, date and place, and due to the death occurred at the time, date and place, and due to the death occurred at the time, date and place, and due to the death occurred at the time, date and place, and due to the death occurred at the time, date and place, and due to the death occurred at the time, date and place, and due to the death occurred at the death occurred	time, date a	and place, and due t	o the cause(s)	
	To With	_	29b. Signature and title of certifier 29c. License number	29d. [Date signed (Month,	Day, Year)	
	10		30. Name and address of person who completed cause of death (flem 23a) (Type, Print) HOUSE CLINE BY SON WHO SET TWENTER TOK NO 2	2176	12110	5	
	Sta Registr		ALANI C. D. / H.H. J. Paragram Pr. Managram				

				partment of Health and Mertificate of Death	ental Hygie	2000	03828	
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
	Physici /Medio		PAULINE ELVINA SHARRER		Month O/	20 05		
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of De		
			St. Catherine's Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Emmitsburg // If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Frederi	inthplace (State or Foreign	
	Funeral Director		213-18-6886 1□M 213F 83 Yrs.	Months Days Hours Min.	Jan. 22,	1921 Ma	ryland	
	P >		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or I					
	laryla show	-0					10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	28a-1	rect	Maryland Frederick Emmitsbu	rg 10f. Zip Code	100	. Citizen of What 0	21	
	3a or	i Di	331 South Seton Avenue	21727	5	U.S.A	,	
	oms 2	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No-	14. Race - Am		
36	or Ite	y Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 🕅 No Specify:	ricari, etc.)	Black, Wh		
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show the Marical Exerciter man be inclined at	ed by	3	edent's Usual Occupation	10	Specify: Wh		
15	n "na	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of working DO NOT use retired)	ng	b. Kind of busines	silindustry	
212	d with	Com		Homemaker		Own H	ome	
nd	be file ital Hy od oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		,		
Z Za	d Men narke natic	2	William Paul Valentine 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	Violet E.			7	
Maryland	id 2 sho ith and 27 is m		11211	ling Address (<i>Street and Number or Rur</i> a est Main Street, Tl			, ,	
re,	t Head f Head item other		20a. Method of Disposition 20b. Place of Disposition			c. Location - City o		
altimore,	Page nent o int: if ury or		1 X Buriai 2 Cremation 3 Chemoval from State	r Luth. Cem. 1/24	/05 Ro	cky Ridg	e, Maryland	
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Department of Health and Mental Hyglene and Proportant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ampropriaty or other traumatic event, Ira M. Jical Examination and the notified at once.		21. Signiture of Juneral Septice Lie mane R	22. Name and Address of Facility. OBERT E. DAILEY & S 15 EAST MAIN STREET	SON FUNER	AL HOMES	, P.A. 1788	
Г			23a Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	r respiratory arrest,		Approximate Interval Between	
	Physician	6 1	Immediate Cause (Final disease or condition resulting in death)	- Al Zhe mee	3D,50	620	Onset and Death	
П	/Medical Examiner		Due to (or as a consex uence of):	119 7 2 2 2 2	1		11 11 2	
		Jer	if any, leading to immediate b. Due to (or as a consequence of):	as process			770	
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.					
50,	cate be executed physician and the burial-transit	I Ex	resulting in death) Last Due to (or as a consequence of):	Due to (or as a consequence of):				
8760,	physicate t	dicai	d					
Box 6	The law requires that the death certific the has been signed by the attending page 2 should be detached to use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of de	olivery	
m.	death e athe	icia	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year	
P. O.	that the de ned by the a detached f	hys	9 ☐ Unknown 9 ☐ Unknown					
	signed d be de	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			to the cause of death?	
orc	w requir been si should I	eted	Menos le spore,		1 Yes	^	robably 4 Unknown	
Records,	has ge 2 s	Completed	a fulo 3 cler of 8		24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of	
Viital	ician: Th certificate rector, pag		25. Was case referred to medical	26. Place of Death	1 Yes 2		s 2 No	
<u> </u>	ysicia is cart direct	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Other	ne 5 Residence	e 6 Other (Spe	ecify)	
0 1	ing Phys After this funeral di	J:uc	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury		8d. Describe how i		,,	
sio	ottor: A the fu	cati	2 Accident investigation	M 1 Tyes 2 No			_	
Division of	I or Atten after deatl Director: I in by the	Certification:	4 Homicide determined 28e. Place of Injury - Athome, farm, s building, etc. (Specify)	reet, factory, office 2	8t. Location (Stree City or Town, S		lural Route Number,	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h. completely filled in by the funeral director, page		29a. Certifier (Check only Medical Examiner: On the basis of examination and/or in	th occurred at the time, date and place, a	nd due to the caus	e(s) and manner a	s stated.	
	To the H within 24 To the F complete	Medicai	one) and manner stated.					
	To You	<	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Mon	ın, vay, rear)	
	(1)		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) (-2/1/4-	1-10	1-21-	2005	
	(4)		BOUTA T. KREWG 1 - DERTIER	DO THURIA	OUT.	117 -	022	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature,	Manusik.	()		1700	
	Registr	ar	JAN 6 4 COOL	H. Commission of the Commissio				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 21,2005 **Physician** Month HENRY SMULLEN HANDY January 1200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mallard Bay Nursing Home Cambridge Dorchester If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1**X** M 2□ F 220-01-9674 Director 87 Yrs. 1917 Maryland 3, Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is markad other than "natural", or itame 23a or 28a-f ehow other traumatic event, the Madical Examinar must be notified at MD Director Dorchester 1 XYes 2 □ No Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45 Delaware Avenue United States Apt. 30 21643 death 1 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after of and Mental Hygiene.

Is marked other than "naturel", or Ital 1 Never Married 2 Married 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pickle Company Processor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edmond Thomas Smullen Ella Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20770 19a. Informant's Name/Relationship (Type, Print) item 27 Is Bernice Smullen/Niece 8511A Greenbelt Rd. Apt.101, Greenbelt, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages nent of h permit. Pages Department of I Important; If its any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State
' 4 □ Donation 5 □ Other (Specify) Chester Cemetery 01/29/05 Rhodesdale, MD 22. Name and Address of Facility
Framptom Funeral Home, P.A
216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee Eskew 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stage Physician Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate the first sequence of the cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): the attending physicien Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy performed certificate 2 No 1 ☐ Yes 2 ☐ Ho 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: 4 Vursing Home 5 Residence 6 Other (Specify) ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Watural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by hours after 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cai 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D47924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AURORA NOMAN 57 CAMBRIDGE THANWY 2/6/3 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 2 6 2005 Registrar

			1- For State of Maryland / Department of Health and M Certificate of Death	lental Hygie	21115	03830
	Physici /Medi		1. Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year	3. Time of Death
	Examir			8. Date of Birth	4c. County of Dea	none
	Funeral Director		214-34-7460 12M 2DF 68 Yrs. Months Days Hours Min. Usual Residence of Decedent	(Month, Day, Ye	ar) Co	thplace (State or Foreign suntry) 9 RY a NO
	he Marylar 8a-f show	ector	10a. State 10b. County 10c. City, Town or Location Del Kent Dover			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	s 23e or 2	Funeral Director	10e. Street and Number 1265 VICTORY Chapel RcL 19904		Citizen of What Co	
5-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show the Medical Exerciter mail tencilitied at	þ	3 ☐ Widowed 4 ☐ Divorced	icity Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
21215-(ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygene. If item 27 is marked other than "natural", or Items 23e or 28e-f show or other treumatic event, If e Medical Exacting transitic event, If e Medical Exacting transitics and the notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ARR FORCE - Rei	ng	Kind of Business	,
Maryland	2 should be filed within and Mental Hygiene. Is marked other than eumatic evant, I're Me	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name MARIO		NEDIC	
	is 1 and 2 shot Health and item 27 Is m other treum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural 19b. Mailing Address (Street and Number or Rural 19c. Mailing Address (Street and Number or Rural 19c. Mailing Address (Street and Number or Rural 19b. Mailing Address (Street and Number or Rural 19b. Mailing Address (Street and Number or Rural 19c. Mailing Address (Street and Number or Rur	el Rd. a		19904
Baltimore,	Pa ant ury		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) CRematicy, crematory or other place)	- 2005 S		4
Ba	Departic Departic Imports any inji		21. Signature of Funeral Service Licensee 22. Name and Address of Facility TRAPER FOREIS 23. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	ier, De	ne 1 19901	Approximate
	Pnysician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to or as a consequence of):			Interval Between Onset and Death 48 Nows
8760,		ai Examiner	Saturately list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Out of Artery Discusse. Due to (or as a consequence of): c. Due to (or as a consequence of):	_		17 years
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23c. If yes, outcome of pregnancy 1		23d. Date of del Month	ivery Day Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I.	23e. Did tobacc	_	the cause of death?
al Records,	ysician: The law re is certificate has bed director, page 2 sho	Completed			prior to death?	topsy findings available completion of cause of
on of Vital	ng Ph fter th ineral	tion; To Be	examiner? 1 Yes 2 YNo	(Check only one) ne 5 Residence 8d. Describe how in		sify)
Division	il or Attandi, after death. Diractor: A d in by the fu	Certification;	Accident investigation M 1 yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 2 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 2	8f. Location (Street City or Town, St		ral Route Number,
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, as the control of the death occurred and manner stated.	nd due to the cause od at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	Total withi Total	M	29b. Signature and title of certifier 29c. License number DEA 11 AU 4176 436	29d. (Date signed (Monti	n, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATHMAD ABSUSTANCIN PM 22 SOUTH GIVELLE ST	vut :	Balto.	MD
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 C 2005 32. Registrar's Signature)	

			1_ For	State o	f Maryland		artment of H		Mental Hyg	iene	05	03831
			Registrar 1. Decedent's Name (First, Middle.	Lact			rtificate of L	Jeath	2. Date of Deat	g. No.		00001
-	Physici	an		, ,	Vacasi	<			Month	Day	Year	3. Time of Death
	/Medic		4a. Fecility Name (If not institution,	DINE	Verger		4b. City, Town, or	Location of Donth	January	2.5	2005 ty of Death	22:08 M
4	Examin	ier	Washington Cour				Hagers					
	Funeral			6. Sex	7. Age (In yrs. la:	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		hingt 9. Birthp	on place (State or Foreign ntry)
	Director		214-09-4370	1□M 2 Q F	8	8 Yrs.	Months Days	Hours Min.	(Month, Day, Aug. 18	Year) 1916	Mary	
1	pu ,		Usual Residence of Decedent		140 00	-						
	anyla shov	<u>_</u>	10a. State 10b. County			Town or Lo					1	10d. Inside City Limits
	Ne M	Director	Maryland Washir	gton	Ha	gerst						1 ▼ Yes 2 No
	with t	늄	10e. Street and Number	a A			10f. Zip Code		10	og. Citizen of	What Cour	ntry?
	na 23	Funerai	916 Pennsylvani		edent Ever in U.S.	12	21742	anania Origina (Se	nosity Vac as Na	USA	ice - Americ	on India
"	fler d	E	1 Never Married 2 Marrie	Armed Fo	rces?	. 13.	Was Decedent of Hi If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)		ack, White,	
93	urs a	by	3 ☑ Widowed 4 □ Divorced	If Yes, Giv Year or D	9		1 ☐ Yes 2 🙀 No	Specify:		Speci	ity: Whi	lte
21215-0036	within 72 hours after death with the Maryland ane. then "natural", or Itema 23e or 28e-f show he Medical Examiner must be notified at	Completed	15. Decedent'	s Education		16a. Dece	dent's Usual Occupa	tion	(d	6b. Kind of E	3usiness/In-	dustry
21	thin 7	npie	(Specify only highest Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	kind of work done d DO NOT use retired,	uring most of won	King			
	filed wi Hygien ther th	Con	12			Offi	ce Clerk			Fairc	hild	
nd	d ta b	Be	17. Father's Name (First, Middle, L					18. Mother's Nam	ie (First, Middle, M	faiden Suma	me)	
Za	should be find Mental I	7	Charles Eldrid		ix				Katheri			
Maryland	12 sh h and 7 Is m raum		19a. Informant's Name/Relationsh				ng Address (Street a			•	, , . ,	/
	s 1 and 2 should of Health and Men Item 27 Is marke other traumatic		Charles A. Verg	ers/Son	20h. Pla	916 F	ennsylvan	iia Avenu		stown,		
Baltimore,			1 X Burial 2 ☐ Cremation				sition (Name of matory or other place	1			,	, -
틒	it. Printmenturbury		' 4 ☐ Donation 5 ☐ Other (Sp 21. Sign Funeral Service L		Rest		en Cemete:	ry 1/2	9/2005 I	lagers	town,	Maryland
Ba	permit. Page Department of Important: If any injury or once.		21. digital district to			1.	. Name and Addres	es Res	st Haven	Funera	al Cha	apel
			23a. Part 1. Enter the disease, or o	complications that c	aused the death.		601 Penns				cown,	Md • 21/42 Approximate
			shock, or heart failure. List of Immediate Cause (Final	nly one cause on e	ach line.		+.	,	,			Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	-	or as a conseque		1545101					
	Examiner			D00 10	Pheun		Ca					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseque							
	cuted nd ransi	Examiner	that initiated events	С.	Dcm.	ent	19					
oʻ	e exe ian a urial-t	EX	resulting in death) Last	Due to (or as a conseque		21					
68760,	icate be executed physician and s the burial-transit	edicai	'	d	HYPR	rlev	Sion					
_	entific ling p	Med	IF FEMALE:									
Вох	The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live bi	come of pregnand irth 2 🗆 Fetal d	eath 3	Ectopic pregnancy				ate of delive onth	Day Year
0	at the de by the a stached f	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊟Pregni 9□Unkno	ant at time of dea own	th 5∟	Other (specify)					,
<u>α</u>	res that tigned by		Part II. Other significant condition	s contributing to de	ath but not resulti	ing in the u	ndertving cause give	n in Part I.	23e. Did toba	acco use con	tribute to th	ne cause of death?
Vital Records,	uires sign d be	d by		-		•	, , ,					ably 4 Unknown
00	w requir been s should	iete							24a. Was an	24h	Wore gute	psy findings available
Re	The tay ate has page 2	Completed							autopsy	. [npletion of cause of
ta		ပိ	25. Was case referred to medical					26 Place of Deat	1 Yes 2 h (Check only one		1 🗆 Yes	2 No
<u>></u>	Physiclan: this certific ral director,	O B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	npatient 2 TEF	VOutpatien	t 3 DOA Othe		ome 5 Resider		ner (Specifi	(1
J Of		L in	27. Manner of Death	28a. Date o		8b. Time of	28c. Injury Work	at	28d. Describe how	v injury occur	red	7
Ö	Attending F r death. ector: After by the funera	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	ition	i, Day 1 ear)	Hijury		es 2 No				
Division	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 286. Place	of Injury · At homing, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (Stre		or or Rura	l Route Number,
	ital o irs afi ral Di	Ce										
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the f	edicai	(Check only 2 Medical E	xeminer: On the ba	isis of examination	edge, death n and/or inv	occurred at the time restigation, in my op	e, date and place, nion, death occur	and due to the cau	use(s) and ma	anner as sta	ated.
	To the To the Complet	Med	one) 29b. Signature and title of certifier	and mann	er stated.							
	1		Transition and title of certifier	muhe	٨		29c. License	06039		d. Date signe		Dey, Year)
0	19		30 Name and addition of	he completed as	a of death floor 5	2-\ (T						
	5		FARID MU	A /	of death (Item 2	Ja) (Type,	Print) (126	of all e		persito	7 /10	
	Sta	te	31. Date filod (Month, Day, Year)	32. Re	gistrar's Signatur	re	-3		WD	1	140	
	Registra	1.0	JAN 28	2005	Posteran d	4. 1	seeds					

			1- For State of Mary		artment of F			ene 0 0 5	03832
	Physic	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	RUTH MARGARET WALKER 4a. Facility Name (If not institution, give street and number)		4h Cihi Tour	s Leaghing of Doorb	Jan.	23, 200 4c. County of Deat	5 6:15 A
	Examir	ier	Salisbury Nursing and Rehab	Center	4b. City, Town, o	r Location of Death Salisbur	bM v	Wicomic	
	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)		If Under 24 Hrs.	8. Date of Birth		
	Director		264-15-9462 ^{1□ M 2} XF	93 Yrs.	Months Days	Hours Min.	02/01/1	911 Inc	nplace (State or Foreign untry) Liana
	land ow		Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary a-f sh	tor	MD Worcester	Ocean I	Pines				1 XYes 2 No
	or 28s	Director	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Co	untry?
	ath wi	ral	35 Hatteras		21811			USA	
920	72 hours after death with the Maryland hatural; or itams 23a or 28a-f show dical Examilise in titled at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Section 11. Marital Status 12. Was Decedent Ever Armed Forces? 1 Section 12. Was Decedent Ever Armed Forces?		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Spean, Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)	14. Race - Ame Black, White Specify: WI	
5-0	72 hours "natural", dic. I Ex	etec	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	ation during most of workin	a 16	Sb. Kind of Business/I	ndustry
121	within iene. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired omemaker			Own Home	•
d 2	filled Hygi thar		17. Father's Name (First, Middle, Last)	- 1	Ollicillanci	18. Mother's Name			-
Maryland 21215-0036	Mer Mer arka	To Be	Lee Smith	1		Emma	Bramble		
Ma	d 2 s h ar 7 is trau		19a. Informant's Name/Relationship (Type, Print) Mary Walker (daughter-in-late)			Ocean Pir		City or Town, State, Z	ip Code)
ē,	- I a =		20a. Method of Disposition 2	0b. Place of Dispo	sition (Name of	Da	2000	c. Location - City or 1	own, State
Ê	2 · = =		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		natory or other place nlopen Ci	rem. 01/25	5/2005	Frankford	, DE
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee		2. Name and Addres	Street Bo	Burbac erlin M	ge Funeral	Home
V			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.						Approximate Interval Between
1	Pnysician	į.	Immediate Cause (Final disease or condition	- 4	-t-	0	>		Onset and Death
	/Medical Examiner		resulting in death)	nsequence of):	Tar.			X	12045
	ZXGIIIII CI	_	Sequentially list conditions, b.	nasquenze of):	and .	e, a	cara.		reary
	nted	Examiner	cause. Enter Underlying Cause (Disease or injury	11334431194 01).					
Ć,	exectin and ial-tra	Еха	that initiated events c. resulting in death) Last Due to (or as a coi	nsequence of):					
8760,	icate be executed physician and s the burial-transit	cal	d						
	ing ph	Med	IF FEMALE:						
Вох	death certific e attending p id for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pr	Fetal death 3	Ectopic pregnancy			23d. Date of deliv	
o. _	he de / the a	yslc	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time 9 ☐ Unknown 9 ☐ Unknown	of death 5	Other (specify)			MOUNT	Day Year
Δ.	that the died by the detached		Part II. Other significant conditions contributing to death but no	t resulting in the ur	nderlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
rds	w requires to be a signer should be a	Q					1 ☐ Yes	2 No 3 Pro	bably 4 Unknown
Vital Record		Completed					24a. Was an	24b. Were auto	opsy findings available
Ä	The hard	mo:					autopsy performed	d? prior to co	mpletion of cause of
ita	Physician: Th this certificate ral director, pag	Bec	25. Was case referred to medical examiner?			26. Place of Death (No 1 Yes	2 140
of <	S S S	၉	1 ☐ Yes 2 ☐ Mo Hospital: 1 ☐ Inpatient	2 ER/Outpatien		4 Chursing Home	e 5 ☐ Residenc	e 6 □Other (Speci	(y)
uc	ding Phi th. After thi funeral	lon:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Day Yea	ar) 28b. Time of Injury	28c. Injury Work	?	ld. Describe how	injury occurred	
Division	Attan deatl ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury	At home farm stre		res 2 □ No	f Location (Stree	t and Number or Run	al Route Number
<u>S</u>	al or / after I Dira	Certification;	4 Homicide determined 256. Place of Injury building, etc. (S _i	pecify)	oot, raciory, ornos	20	City or Town, S	State)	ar noble Walliber,
	ospit hours unara ly fille		29a. Certifier 11 Certifying Physician: To the best of my	knowledge, death	occurred at the tim	e, date and place, an	d due to the caus	e(s) and manner as s	stated.
	To the Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	Medical	one) 2 Medical Examiner: On the basis of examiner and manner stated.	mination and/or inv	estigation, in my op	pinion, death occurred	at the time, date	and place, and due t	o the cause(s)
	To To To To To To To To To To To To To T	2	29b. Signature and title of certile r		29c. License	number	29d.	Date signed (Month,	Day, Year)
			1. Comment		125	1381		1/2 4/1	5
14	3#		30. Name and address of person who completed cause of death WILLIAM ROBINS, M.D. 200 C		Print) - , SALISBU	DV MD '	21804		
	Sta	e	31. Date filed (Month, Day, Year) 32. Jegistrar's S	ignature		NI/ PID - 2	77004		
	Registr		JAN 2 5 2005	J. Ag	rade				

			1 - State of Maryland / Department	artment of Health and Martificate of Death		gieme)	5 03833
E			Decedent's Name (First, Middle, Last)	······································	2. Date of Dea	ath	3. Time of Death
П	Physici		Dosia Williams		Month	Day	Year 1:30 AM
}	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	January	23 20 4c. County	
	Examir	er					
			Villa Rosa Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Mitchellville If Under 1 Year If Under 24 Hrs.	8. Date of Birt		e George 9. Birthplace (State or Foreign
	Funeral Director		1 TM 2FT S	Months Days Hours Min.	(Month, Day	/, Year)	Country)
	Director		239-22-4652		Jan. 6,	1906	North Carolina
	land		10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
	Aary Fehr	ō	Maryland Prince George Upper Man	-1boro			1 ☑ Yes 2 ☐ No
	the ?	Director	10e. Street and Number	10f. Zip Code		10- 00	M-10
	with					10g. Citizen of V	what Country?
	s 23	ra	11010 Woodlawn Boulevard	20774		United	
	be filed within 72 hours after death with the Maryland hat Hygiene. sd other than "netural", or items 23a or 28a-f show event, the Medical Exan front must be ricitled at	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American Indian, ck, White, etc.
36	s aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:		Specify	· Black
8	urai urai	D D	3 ☑ Widowed 4 □ Divorced Year or Dates:				
21215-0036	"nei	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ring	16b. Kind of Br	usiness/Industry
5	withir han	E D	Elementary/Secondary (0-12) College (1-4or 5+)				
7	lied v lygie her i		17. Father's Name (First, Middle, Last)	r Parent	- /Final Middle	Privat	*
Ĭ,	m = 0 <	Be		18. Mother's Name			1B)
₹	should be filed withir nd Mental Hygiene. marked other than matic event, Ins Ma	스	Doreamus Williams, Sr.		Shack1		
Maryland	2 sh and is m			ng Address (Street and Number or Run			
	and ealth 127 m 27			Woodlawn Blvd.,			
ore	of H fiter		20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposemetery, cremation cemetery, cremation 2 ☑ Cremation 3 ☑ Removal from State	sition (Name of natory or other place)	Date	20c. Location -	City or Town, State
Ĕ	Pag nent ant: I		'4 Donation 5 Other (Specify) Church Ce	metery, NC 1/29/	05		North Carolin
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic events.		21. Signature of Funeral Service Licensee	Name and Address of Facility exander S. Pope F	uneral	Homes	
				38 Marlboro Pike,			MD 20747 Approximate
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one seuse on each line.				Interval Between
P	Physician .		Immediate Cause (Final disease or condition resulting in death)	the Heart	DIS	ase	Jeans
	/Medical Examiner		Due to (or as a consequence of):	Candio Vas Cu			0
		_	Sequentially list conditions, b.	Candio Vas Ce	la.	DISta	u years
	sit sit	lne	if any, leading to immediate Due to or as a consequence of): cause. Enter Underlying Cause (Disease or injury				
	ecuta and tran	Examiner	that initiated events c.				
ő,	se ex	E	Due to (or as a consequence of):				
58760,	tificate be executad g physician and as the burial-transit	edlcal	d				
_	ntific ing p		IF FEMALE:				
Box	death certifi e attending id for use as	an/l	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy			te of delivery
	0 0 0	Physiclan/M	1 Yes 2 No	Other (specify)		Mo	onth Day Year
0	at the de by the a stached	چ	9 DONKHOWN				
- Ś	The law requires that the sta has baen signed by th page 2 should ba detache	by F	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did to	obacco use cont	ribute to the cause of death?
2	quire an sig uld b		Dementia		101	es 2 No	3 Probably 4 Unknown
ပ္ပ	s bae	Completed			24a. Was	an 24b.	Were autopsy findings available
Record	: The law cata has l	Ĕ			autop perfo	rmed/?	prior to completion of cause of death?
_	icien: Th certificata rector, pag	ပိ	25. Was case referred to medical		1 Yes		1 ☐ Yes 2 ☐ No
5	certi	o Be	examiner?	26. Place of Deat			
o	Phys this ral di	H- H	1 ☐ Yes 2 ② No ☐ 1 ☐ Inpatient 2 ☐ ER/Outpatien 27. Manner of Death 28a. Date of Injury 28b. Time of	4 A Nursing Ho	ome 5 Resid		
L N	ling After fune	5	1 Natural 5 Pending (Month, Day Year) Injury	Work?	200. Describe r	ion arguly occur	160
<u>S</u>	tand Jeath tor: the	cat	2 Accident investigation 3 Suicide 6 Could not be 380 Blace of Injury 4t home form at	M 1 Yes 2 No	0001 11 11 11		
Division of Vital	or Al fter c yirec n by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	City or Tox		per or Rural Route Number,
	rs a			1			
	To the Hospitel or Attending Physicien: Whin's 4b hours after death. 25 the Funeral Director: After this certifies completely filled in by the funeral director; p	Medical	29a. Certifier (Check only construction) (Check only construction) (Check only construction) (Check only construction) (Check only construction) (Check only construction) (Check only construction) (Check only construction)	occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the	cause(s) and ma	anner as stated. and due to the cause(s)
	the lin 2 the lin 2 the line line line line line line line lin	Jed	and manner stated.				
	P 3 2 8	<	29b. Signature and title of certifier	29c. License number	~	29d. Date signe	d (Month, Day, Year)
•	(1)		Kakesh onong	D2010	8	01/2	6/05
	Sp		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	1 -	1	
	90		Kakesh Hrora, M.D.	14500 Gal an	st tox	LN, L	Dowie MD 20715
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 2 6 2005			/	
	Registr	ir .	John Court of Sparke	1			

			1 - State Registrar	State of	Marylan		artmen rtificate				lental Hy	gien	UUD	03834
	Dhyoisi		1. Decedent's Name (First, Middle	e, Last)	-						2. Oate of De Month	ath Da	ay Year	3. Time of Death
	Physici /Medic		Eleanor W								Janua		27,200	- 14
	Examin	er	4a. Facility Name (If not institution		,			_	Location of	of Death		40	c. County of Dea	ath
			Ruxton Heal 5. Social Security Number		ton Age (In yrs.	last hirthday	If Under	Den	ton If Under	24 Hrs	O Data of Di-		Caroli	
	Funeral Director		213-22-9255 Usual Residence of Decedent	1 M 2 7	9		Months	Days	Hours	Min.	B. Date of Bir (Month, Da Mar.	y, Year	913 Ma	irthplace (State or Foreign Country) aryland
	/land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	after death with the Marylar or itams 23a or 28a-f show	tor	MD Carol	ine		De	nton							1 ☐ Yes 2 🕱 No
	th the or 28s	Director	10e. Street and Number			-	10f. Zip	Code				10g. Ci	itizen of What C	Country?
	23a (23a)	ai	420 Colonial	Drive				216	529			Un	ited S	tates
	or deg	Funerai	11. Marital Status	12. Was Decede Armed Force	es?	.S. 13.	Was Deced	ent of Hi	spanic Ori n, Mexican	gin? (Spe	cify Yes or No Rican, etc.)	-	14. Race - Am Black, Wh	
36	s afte	by Fi	1 Never Married 2 Marr 3 Widowed 4 Divorced	If Yes, Give			1 ☐ Yes 2		Specify:					White
S	be filed within 72 hours after death with the Maryland ital Hygiene. In the matural, or Itams 23a or 28a-f show avent, it a Medical Exart met must be indiffed at avent, it a Medical Exart met must be indiffed at		15. Deceden	Year or Date	35.	16a Dece	dent's Usua	I Occupa	ation	-		16b k	(ind of Business	
715	nin 72 n n	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4	\	(Give	kind of wor DO NOT us	k done d e retired	luring mos	t of worki	ng	100.1	and or business	sindustry
212	e filed within al Hygiene. other than "vant, It a Me	mo	6	College (1-4	Of 5+)	Stor	e Owi	ner/	'Oper	ato	r	G	rocery	Store
b	be file ital Hy id othe avant	Be C	17. Father's Name (First, Middle,						18. Mothe		(First, Middle,		*	
<u>کاھ</u>	should b ind Menti markad umatic a	To	Harold Sher	man						Ros	etta I	'à O I	ns	
lar	2 should be and Mental Is markad c		19a. Informant's Name/Relations							or Or Rura	l Route Numbe	er, City	or Town, State,	Zip Code)
Baltimore, Maryland 21215-0036	D = 1		Barbara Ann	Moore/Dau	ighter	P.(D. Bo	x 4	21,	Fed	eralsb		, MD	
õ	in of h		20a. Method of Disposition 1 → Burial 2 □ Cremation	3 □Removal from Sta	ate C	lace of Dispo emetery, crer	natory or ot	her place		01/	ate		ocation - City or	
ij	permit. Pa Departmen Important: any injury		`4 ☐Donation 5 ☐ Other (S)		E1	ldorac					-			, Maryland
Ba	permit. Pages 1 and Department of Heall Important: If itam 2 any injury or other once.		21. Signature of Funeral Service	Licensee /	An An		. Name and			1.1.4	amptom	Fu	neral	Home, P.A.
			23a. Part1. Enter the disease, or	complications that cau	sed the death	Do not ent	er the mode	• PI	aln	DL.	, reue	rgr	sburg,	MD 21632
4	Di		shock, or heart failure. List	only one cause on eac	h line.						2277	1031,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		as a consequ		ART	210	MY	PA	TMY			YEARS
	Examiner				-		XRV.		Die	LLV	DART	B	VUG	NLADE
_		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Underlying Cause (Disease or injury)								1100	424	7 + 1	IEMR)
	cuted nd ransit	Examin	trial iriitiated everits	, <u>1</u> 2	4 TPE	RTEN	5101							YEARS
O	e exerian ar	EX	resulting in death) Last	Due to (or	as a consequ	uence of):					-			
8760,	icate be executed physician and s the burial-transit	dicai		d										
9	n certific anding p use as	Med	IF FEMALE:											
Box	leath certifi attending	Physician/Me	23b. Was decedent pregnant in the past 12 months?		n 2 ☐ Fetal	death 3	Ectopic pre						23d. Date of de Month	olivery Day Year
o.	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnan 9□ Unknow	it at time of de n	ath 5∟	Other (spe	ecify)				ĺ		,
<u> </u>	that the death led by the atter detached for u	/ Ph	Part II. Other significant condition	ns contributing to deat	h but not resu	alting in the ur	nderlying ca	use give	n in Part I.		23e. Did to	bacco	use contribute to	o the cause of death?
Records,	luires tha signed I	d by	ATRIAL FUR	RILLATIO	NA	L2 HEIP	YER!	5)EMÉN	AIT	1 □ Y	es 2	□No 3 P	robably 4 Unknown
00	w requir been si should	jete			1 .						24a. Was a		24h Were a	utopsy findings available
Be	Physician: The law requires that the death certificate has been signed by the attending trail director, page 2 should be detached for use as	Completed									autop perfor	sy med?	prior to death?	completion of cause of
Vital		Be C	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes	2 No	1 □ Yes	s 2 X No
_	ysici is cer direc	0	examiner? 1 □ Yes 2 ¼ No	Hospital: 1 _ Inp	atient 2	ER/Outpatien	t 3 🗆 DO	A Othe				-	6 ☐Other (Spe	acify)
0	ng Phys ter this neral di	J: L	27. Manner of Death 1. Natural 5 Pending	28a. Date of I	njury Day Year)	28b. Time of Injury	28	Bc. Injury Work	at		8d. Describe h			
0	ttandir death. ctor: Al	atic	2 Accident investig	ation	, ,	,,	М		es 2□h	No				
Division of	for Att after de Diract	Certification:	3 Suicide 6 Could r 4 Homicide determi	ned 288. Place of	Injury - At ho etc. (Specify	me, farm, str	et, factory,	office		2	8f. Location (S City or Tow	treet an n, State	nd Number or Ri	ural Route Number,
	urs al urs al aral D									- 1				
	Hospita 24 hours Funaral etely filled	Medicai	29a. Certifier 1 Certifyin (Check only 2 Medical I	g Physician: To the be Examiner: On the basi	s or examinat	wledge, death ion and/or inv	occurred a estigation,	it the tim in my op	e, date and inion, deat	d place, a h occurre	nd due to the c id at the time, c	ause(s) late and) and manner as d place, and due	s stated. e to the cause(s)
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director,	Me	29b. Signature and title of certifier	and manner	1		29c.	License	number	-	2	29d. Dat	te signed (Mont	th, Day, Year)
	- s - ō		Valanh.	KKK 1-	TTE AIN	INC M	DY	700	250	29	4	1-	21-0	(
			30. Name and addres of person	who completed cause of	of death (Item	23a) (Tyne	Print)		~ ·	9 1		1	>1-0	3
			12 80	NBOD 3	321 7	3000	MING	DA	18 1	NEX	EDAN	S	BRG.	$\mathcal{M}(\mathcal{I})$
	Sta		31. Date filed (Month, Day, Year)	32. Reg	istrar's Signat	-	AND IN	1						
	Registr	ar	FEB - 1 20	05	w St.	A STATE OF THE STA	A STATE OF THE PARTY OF THE PAR							

			. For	State of Marylar	nd / Depa	artment of H	lealth and M	lental Hy	giene	A	
			1 - State Registrar		Ce	rtificate of	Death	F	Reg. No. 2 U	05	0383
	Physici /Medi		1. Decedent's Name (First, Middle, Last)	MW	NEAT	MAN		2. Date of Dea Month	Day24	Year 200 5	3. Time of Death 7: DS P M
	Examir		4a. Fecility Name (If not institution, give	street and number)	1-1		Location of Death		4c. County	of Death	
			KUXTON				10N		CAR	DILLY	JE
	Funeral Director		217-05-5058	7. Age (In yrs	last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Novemb	v. Year 1909	9. Birthpla Count Del	ace (State or Foreigi try) aware
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10	Od. Inside City Limits
	Ba-1 s	ector	Maryland Caroline	<u> </u>	Dento						1√2 Yes 2 □ No
	3a or 2	Funeral Director	10e. Street and Number 602 North Sixth St	root		10f. Zip Code 21629			10g. Citizen of V United	States	s of
	death ms 2:	era		12. Was Decedent Ever in U		Was Decedent of H	ispanic Origin? (Spe	cify Yes or No-	14. Rac	e - America	
920	be filed within 72 hours after death with the Maryland lat Hygiene. Id other than "natural", or Items 23a or 28a-1 show event, the Medical Exart art must be neuthed at	þ	1 Never Married 2 Married 3 🔀 Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		if Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	Rican, etc.)	Specify		
9	72 ho	ted	15. Decedent's Edu (Specify only highest grade		16a. Dece	dent's Usual Occup	ation during most of worki	20	16b. Kind of Bu	JCasia usiness/Indu	
21215-0036	within 7 jiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	arpenter	during most of worki	ng	Const	tructi	ion
	be filed tal Hygid d other event, t	Be C	17. Father's Name (First, Middle, Last)	_			18. Mother's Name	(First, Middle,			2011
<u>Ja</u>		To	Edgar Carr	coll Wheatman			Mary	Hester	Smith		
Maryland	2 sh and is m	100	19a. Informant's Name/Relationship (Ty	•			and Number or Rura				,
	s 1 and f Health item 27 other tr		Robert Wheatman	Son			ighway, D				
Baltimore,	00-		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval nom State		sition (Name of natory or other place Crematory		2005	20c. Location -		
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	Name	22 N	Name and Address	ss of Facility eral Home,	P.A.			
	Medical Examiner the purial-transil	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line.	quence of):		UŁ Pum				Interval Between Onset and Death
68760,	cate b physic the bi	edical								-	
Box	ath certif attending for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pregnancy Other (specity)			23d. Dat	e of deliver	'Y Day Year
Vital Records, P.O.	quires that the de n signed by the a uld be detached t	by	Part II. Other significant conditions cor COLGESTUK b		sulting in the u	nderlying cause give	en in Part I.		bacco use conti	ibute to the	e cause of death?
eco	e law requires has been sign je 2 should be	Completed				1		24a. Was a	an 24b. V	Vere autop:	sy findings available
E.	Thate are	Com						perfor	med?	leath?	21/2 No
/ita	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only or	78)		
of \	Physician: this certific ral director,	은	1 ☐ Yes 2 No		ER/Outpatien		4 Nursing nor				1
Division	Attending I r death. ector: After by the funer	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work M 1 []	Yes 2 □ No	28a. Describe n	ow injury occurr	ea	
DIVE	al or Att	Sertifle	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str ify)	eet, factory, office	4	28f. Location (S City or Tow	treet and Number, State)	er or Rural	Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical C	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination	sician: To the best of my kn ner: On the basis of examinand manner stated.	owledge, death ation and/or in	occurred at the time vestigation, in my op	ne, date and place, a pinion, death occurre	and due to the c	ause(s) and ma late and place, a	nner as sta and due to t	ited. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1//1		29c. License		2	29d. Date signed	I (Month, D	ay, Year)
)			1-1/2/uh	Whe Hotel	DING	D00	53094		01-29	5-03	5

State Registrar

31. Date filed (Month, Day, Year)

PEINSON S L ar) 32. Registrar's Signature

01-25-05

		·	For State Registrar		aryland / Depa Cei	artment of H			Reg. No.	05	03836
	Physici /Medic		Decedent's Name (First, Middle, Las Mary Lou	u William	າຣ			2. Date of De Month	y aa	abo5	3. Time of Death
	Examin		4a. Facility Name (If not institution, give Memorial Hos)	sital	# 1	4b. City, Town, or Eastor	Location of Death If Under 24 Hrs.	8. Date of Bin	Ta	Ibot	
	Funeral Director		5. Social Security Number 6. S 218-24-4573 Usual Residence of Decedent	ox 7. Age □ M 2□xF	(In yrs. last birthday)	Months Days	Hours Min.	(Month, Da	y, Year)	Coun	ace (State or Foreign try) ryland
	Maryland f show led at	ō	10a. State 10b. County Maryland Carolin	20	10c. City, Town or Lo Denton	ocation				10	Od. Inside City Limits
	with the P a or 28a- Lee notifi	Director	10e. Street and Number		Delitori	10f. Zip Code 21629				1 State	
336	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-1 show event, the Medical Examinat must be notified at	by Funerai	8951 New Bridge I 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Diverced	12. Was Decedent R Armed Forces? 1 ☐ Yes 2€ N If Yes, Give Year or Dates:	Ever in U.S. 13. 1	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sin, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	Spec	nerica lace - Americ Black, White, c cify: Caucasi	etc.
21215-0036	d within 72 hou piene. r than "nature the Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 11 HS Grad	ucation de completed) College (1-4or 5	+) (Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wor i)	king	16b. Kind of	Business/Ind	
and	ould be filed Mental Hygidarks of ther latic event, I	Be	17. Father's Name (First, Middle, Last)	G 1		rebuone (T8. Mother's Nan		Maiden Sum		
Maryland	S D E E	٦ ر	19a. Informant's Name/Relationship (ng Address (Street a	and Number or Ru		er, City or Tow		
	ges 1 and 2 it of Health a if Item 27 is or other tree		Michael S. Willia 20a. Method of Disposition		20b. Place of Dispo	Palmer's sition (Name of natory or other place	e)	Date	20c. Location	n - City or To	wn, State
altimore,	t. Pa rtmen rtent:		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifical States of Funeral Service Licer	')	Denton	Cemetery Name and Address Oore Fune	1/28		Denton	, Mary	land
Ö .	Depa Impor		23a. Part 1. Enter the disease, or com	olications that caused		12 South	Second S	treet, D		Maryla	nd 21629 Approximate
	Physician /Medical Examiner	ner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a fundamental de la fundamental de	cerebre	vascula lation	r aeci	dent			Interval Between Onset and Death
68760,	ifficate be executed g physician and as the burial-transit	ledicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	a consequence of):						
.O. Box	The law requires that the death certif te has been signed by the ettending tage Z should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)				Date of delive Month	ry Day Year
rds, P	w requires that been signed t should be deta	by	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in the u	nderlying cause give	en in Part I.		obacco use co Yes 2 🖳 No		a cause of death?
of Vital Records,		Completed								prior to con death?	esy findings available apletion of cause of
Vita	Physicien: 1 this certifical ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ₺ No	Hospital:	nt 2 ☐ ER/Outpatier	nt 3 DOA Othe	26. Place of Dea er: 4 ☐ Nursing H	th <i>(Check only o</i> ome 5 ☐ Resid		Other (Specify)
ion of	utending Phy death. ctor: After thi y the funeral o	ertification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day		Work	/ at k? Yes 2 □ No	28d. Describe h	now injury occ	urred	
Division		Certific	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (5 City or Tox	Street and Nur vn, State)	m <i>ber or Rur</i> al	Route Number,
	To the Hospitel or I within 24 hours after To the Funeral Direction completely filled in b	edical (of my knowledge, deatle examination and/or in- ited.						
	To th withir To th	Me	29b. Signature and title of certifier	Tses"		29c. License	o number 95948		29d. Date sign	3/05	oay, Year)
	Sta Registi		30. Name and address of person who John Botsis, M. 31. Date filed (Month, Day, Year)	D., 219	eath (Item 23a) (Type, South Wa. ar's Signature	shingtor	n Street	, East	on, M	aryla	nd 21601

			For State of Mar		artment of H			iene	15 120	27
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last) LC+C MACK F 4a. Facility Name (If not institution, give street and number)	Bellany	Ab City Tours or	Lagation of Dooth	2. Date of Death Month	Day	03 1.101	M C
	Examin Funeral Director	er	SINNUccington Rd. 5. Social Security Number 6. Sex 17. Age (241.28.7475 19M 20F	(In yrs. last birthday)	tf Under 1 Year Months Days	Location of Death Hinner If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	4c. County of	9. Birthplace (State or Fo	oreign
	ne Maryland 8a-f ehow diffied at	ector	MD NIA	10c. City, Town or Lo	timore				10d. Inside City Li	
	eath with ti ne 23a or 2 mint be n	Funeral Director	10e. Street and Number SIA N. Wordington Road 11. Marital Status 12. Was Decedent Ev			21229		og. Citizen of W	hat Country? SA - American Indian,	
5-0036	172 hours after death with the Marylan "natural", or iteme 23a or 28a-f show ideal Evantinar must be rediffed at	by	Armed Forces? 1 Never Married 2 Married tf Yes, Give Year or Dates:		I ☐ Yes 2 X No	ispanic Origin? (Spe n, Mexican, Puerto I Specify:	Rican, etc.)		, White, etc. Black	
21215-		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College,(1-4or 5+)	(Give	lent's Usuat Occupa kind of work done of DO NOT use retired	ation during most of workin)	ng 1	Shy	oness/Industry Outd	
ryland	2 should be filed with and Mental Hyglene, is marked other that aumatic event, It an	To Be (17. Father's Name (First, Middle, Last) William Bellamy 19a. Informant's Name/Relationship (Ty. Print)	10h Maille	a Address (Street		evenso	n		
15	s 1 and 2 si if Health an item 27 is r other traur		Belty J. Bellany/Wife 20a. Method of Disposition	20b. Place of Dispo	N. N.000		Rd. B	altimo	rare, Zip Code) 22 MD 2122 City or Town, State	29
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Importent: If item 27 is marked other than eny injury or other traumatic event, I.e. MODEs.		1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Crawn	SVIILE	is of Facility reene Fi			nsville, Mi	>
	Physician		23a. Part1. Enter the disease, or complications that caused the shock, or hear failure. List only one cause on each line. Immediate Cause (Final	ne death. Do not enti	er the mode of dying				Approximate Interval Between Onset and Deat	n th
	/Medical Examiner	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	consequence of):						
P.O. Box 6	I the death certiff by the attending ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. tf yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tin 9 □ Unknown	Fetat death 3	Ectopic pregnancy Other (specify)		-	23d. Date Mont	of delivery h Day Year	
ords, P	eduires that en signed b	by	Part II. Other significant conditions contributing to death but i	not resulting in the ur	iderlying cause give	en in Part I.		acco use contrib	oute to the cause of death	
al Reco	ysician: The law re is certificate has be director, page 2 sho	Completed						ed? de	ere autopsy findings avail or to completion of cause ath? Yes 2 \(\) No	able of
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within C4 brous after death. To the Funnet Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be	25. Was case referred to medical examiner? 1	- At home, farm, stre	28c. Injury Work M 1 \(\) Y	res 2□No	ne 5 Resider 8d. Describe hov 8f. Location (Stre	nce 6 Other		
Ď	Hospital or 24 hours afte Funeral Dir tely filled in	edicai Cert	29a. Certifier (Check only Medical Examiner: On the basis of examiner)	my knowledge, death	occurred at the time	e, date and place, a inion, death occurre	City or Town, nd due to the cau d at the time, dat	ISB(S) and man	ner as stated. d due to the cause(s)	
	To the To the Complex	Med	one) and manner stated 29b. Signature and title of certifier B. K. Sulland	· . D	29c. License				Month, Day, Year)	
	\U Sta	te	30. Name and address of person the completed cause of deal BK 12 NK FF M 0 31. Date filed (Month, Day, Year) 32. Registrar's	10 N.	GV. 64 MG	. 72	BULL	Temos	e DiD 212	101
DHN	Registr	ar	FEB 0 9 2005 Recur	# for	Ales					

			. 101	artment of Health and Mental H	lygiene 005 03838
ľ	Physici	an a	Decedent's Name (First, Middle, Last)	2. Date of Month	Death 3. Time of Death
	/Medic Examin	al	STELLA LOUISE BOCZE 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	05 2001 7 30 M
	Examilia	ę,	GOOD SAMARITAN HOSTITAL	BALTIMORE, MD	NA
	Funeral Director		5. Social Security Number 214-50-1831 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Yrs.		Birth 9. Birthplace (State or Foreign Country)
			Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	06/15	/ 1946 Maryland 10d. Inside City Limits
	Manyla	tor		ltimore	1 √ Yes 2 No
	or 28s	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country? U.S.A.
	leath v	Funerai	1027 Cathedral Street 11. Marital Status 12. Was Decedent Ever in U.S. 13. V	21201 Was Decedent of Hispanic Origin? (Specify Yes or	
036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itams 23a or 28a-f show ant, It a Madical Exportment rual te neillised at	by	1 Never Married 2 Married 1 Yes 2 110	Was Decedent of Hispanic Origin? (Specify Yes or if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes No Specify:	Black, White, etc. Specify: Black
2-0	72 ho	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	16b. Kind of Business/Industry
2121	within jiene.	ompi	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) elder	Copper
Maryland 21215-0036	d dal	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mide	dle, Maiden Sumame)
ryla	should I	은	Naaman Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	Mvrtilla Simmon	
	1 and 2 sho Health and Ism 27 is mu			illiamsbury Ct., Edgewoo	
ore,	Pages 1 and the solution of th		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cremation 3 ☐ Removal from State	natory or other place)	20c. Location - City or Town, State
altimore,			'4 ☐ Donation 5 ☐ Other (Specify) Arbutus (21. Signature of Funeral Service Licenses 22		Baltimore, Maryland
Ba	permit. Departn Imports any inju		40	2. Name and Address of Facility The Derri Oll Park Hgts, Ave., Ba	ltimore, Maryland 21215
H	W.		23a. Part1. Enter the disease, or complications that used the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or respiratory	y arrest, Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. HEPATIC EV Due to (or as a consequence of):	NCEPHALOPATHY	
	Examiner				
	bed risit	Exan iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
ó	be executed sician and burial-transit	Ехаг	that initiated events c		
8760	icate be physici s the bu	dicai	d		
Вох 6	eath certific attending p	0	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	75	23d. Date of delivery
O. B.	at the death by the atte	Physician/M		JEctopic pregnancy ☐ Other (specify)	Month Day Year
<u>a</u>	res that th igned by be detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I. 23e. Di	id tobacco use contribute to the cause of death?
ords	w require: been sig should b		DIABETIS MELLITUS	1[Yes 2 No 3 Probably 4 Onknown
Records,	e la has je 2	Completed		, pe	prior to completion of cause of death?
Vita		a	25. Was case referred to medical	1 ☐ Yes 26. Place of Death (Check onl	
	Physici this cer al direc	To B	examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatien		esidence 6 Other (Specify)
ono	iding F th. After funera	tion;	27. Manner of Death 1 Natural 5 Pending 2 Accident Accident Accident Solution 28b. Time of Injury 28b. Time of Injury (Month, Day Year) Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	e how injury occurred
Division of	To the Hospital or Attending Physicien: within 24 hours after death. To the Funaral Director: After this certifical completely filled in by the funeral director,	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, structure building, etc. (Specify)		n (Street and Number or Rural Route Number, Town, State)
	a Hospit. 124 hour: a Funara letely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death one) 29a. Certifier (Check only one) 1 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, and due to the vestigation, in my opinion, death occurred at the time.	he cause(s) and manner as stated. ne, date and place, and due to the cause(s)
	To th withir To th comp	M	29b. Signature and title of certifier A D	29c. License number	29d. Date signed (Month, Day, Year)
	7	4	30. Name and address of person who completed cause of death (Item 23a) (Type,	D0058009	02/05/05
	Sta	to:	ZELAIEM MAKONNEN 5601 LOCH RAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature		ole, MD 21239
100	Registr		FEB - 9 2005 Flating # for	to a second	

Deborah A. Bunk Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-0021 1- State of Maryland / Department of Health and Mental Hygiene 23a,27,28a-f per me 1840 2-17-05 tas

Certificate of Death **AKG** Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 2005^{Year} Deborah A. Bunk January 1:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1846 North Collington Avenue Baltimore 5. Social Security NumberUnk 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 23, 19 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country) unk Days Months Hours 1 □ M 2 🛛 F 43 Yrs Director 1961 Usual Residence of Decedent Maryland 10a, State 10b. County 10c. City, Town or Location 28a-f show 10d, Inside City Limits traumatic evant, the Medical Examiner must be notified at MD Baltimore Director 1√ Yes 2 No with the 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4210 Parkmont Avenue Itams 23a 21206 Funeral death USA unk 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after on and Mental Hygiene. 'is marked other than "natural", or Ital Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married unk Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No à Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
unk 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) unk Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) unk unk 1 and 2 should be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a important: If itam 27 is any injury or other tra O.C.M.E. 111 Penn Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □Donation 5 XOther (Specify) in state? 21. Signature Funeral Service Licensee Ronal S. Wade: Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part i Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, acheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Narcotic and Alcohol Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit and The law requires that the death certificate be exec Due to (or as a consequence of): attending physician P.O. Box 68760 Physiclan/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) YAS 2 No 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 70 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? certificate 2□No To the Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA XXYes 2□No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Scene Certification: To 27. Manner of Death 28a. Date of Injury **ForMid**h, Day **1-05** 28b. Time of 28d. Describe how injury occurred After Japital c. 24 hours after des. "agral Director: After "n by the fu 1 Natural 5 Pending investigation Found 1 ☐ Yes 2 🗶 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number City or Town, State) 846 N. COLLINGTON determined 4 Homicide To the Funaral Div Ave., Found behind vacant building Baltimore, Md 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 2, 2005

State Registrar

DHMH 17 Rev 1/2001

111 Penn Street, Baltimore, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

Registrar's Signat

MANYS MIDS

j°g

			1 - For State Registrar	State of Marylan		rtment of tificate of			ene . No. 200	ร กระเก
	Physic		1. Decedent's Name (First, Middle, Last) VANN (BROW			2. Date of Death Amonth Tenyva	Day Xear	3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, give s				or Location of Death		4d. County of De	ath
	Funeral Director		5. Social Security Number 6. Sex 213-40-0379	7. Age (In yrs.	last birthday) 3 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y	9. B	rthplace (State or Foreign ountry)
	faryland show	ō	Usual Residence of Decedent 10a. State 10b. County Md.	10c. Cit	y, Town or Loc	ation , mok	20			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the Ma s or 28a-1 : Le retiffe	Direct	10e Street and Number	iton Ave		10f. Zip Code	21205	10g	. Citizen of What C	<u></u>
و لو.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23s or 28s-f show eny injury or other traumatic event, I'm Medical Examiner must be notified at 000s.	by Funeral Director	/ / /	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No	S. 13. W	/	Hispanic Origin? (Spi ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
AAMMÍ 121215-0036	"neturel",	eted by	3 🖭 Widowed 4 □ Divorced 15. Decedent's Educ (Specify only highest grade		16a. Decede	☐ Yes 2 No ont's Usual Occu ind of work done	pation during most of worki	ing 16	b. Kind of Busines:	Lack, s/industry
	filed within Hygiene. other then sert, the Me	Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		ate c	of Mary	Land &		Worker
\mathcal{M}_{1} Maryland	should be filed and Mental Hygi is marked other aumatic event, I	To Be	21	U15	19b Mailing	Address /Stree		e P. Ba	11	7-0-11
	ss 1 and 2 s of Health ar item 27 is other trau		0: 1 0 >	is Kreve 200. P	363	Som (Name of	th Point	Load R	ecduill, p. Location - City o	A. 22539
Baltimore,	permit. Pages Department of I Importent: If it eny injury or o		1 Burial 2 Cremation 3 Re '4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	5+	John 13	Name and Address	tepy 2/1	2/05 K	ILMAPNO ROADW	ock , Vas
ä	permi Depa Impo eny ir		23a Part1. Enter the disease, or complice shock, or heart failure. List only on	Cations that caused the death e cause on each line.	. Do not enter	the mode of dy	10101000	itan Ch		Approximate
	Physician /Medical	/	Immediate Cause (Final disease or condition resulting in death)		ience of):	nfic	kidne	> Lunc	<i>v</i>	Interval Between Onset and Death
K	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ience of):					
√	icate be executed physician and s the burial-transit	i Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequ	sence of):					
x 68760,	eath certificate be attending physicia for use as the bur	/Medicai	d.	Bc. If yes, outcome of pregnar						
P.O. Box	that the death of the death of the detached for us	Physician/M	23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 □E	ctopic pregnanc Other (specify) _	у		23d. Date of de Month	livery Day Year
rds, P	juires that the signed by ald be detacted	by	Part II. Other significant conditions conf	tributing to death but not resu	Iting in the und	erlying cause gr	ven in Part I.	23e. Did tobacc	/	o the cause of death?
Division of Vital Records,	To the Hospitel or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed						24a. Was an autopsy performed	death?	utopsy findings available completion of cause of
f Vital	ysician: Th is certificate director, pag	To Be C	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient	3□ DOA O#	26. Place of Death	1 Yes 2 ✓ (Check only one) ne 5 Residence		2□No
ion o	Attending Physical death.		27. Manner of Death 1		28b. Time of Injury	28c. Injui Wor		8d. Describe how in		city) hospice
Divis	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,				8f. Location (Street City or Town, St	ate)	
	the Hosp thin 24 hou the Sune mpletely fil	Medical	one)	ician: To the best of my know er: On the basis of examinati and manner stated.	vledge, death o on and/or inves	stigation, in my o	ppinion, death occurre	d at the time, date a	and place, and due	to the cause(s)
	7.	-	29b. Signature and title of certifier	D			854	29d.	Date signed (Mont	.005
	X		30. Name and address of person who con Covident Riseber 31. Date filed (Month, Day, Year)	72. 5-	Paul		Himore	md. 2	1202	
	Sta Registra		FFB - 9 2005	Sicare A.	Appent.	W			,	

			State of State of Registrar	Maryland / Dep	partment of Fertificate of			iene g. No20 (05 03	3841
	Dhysiai	20	1. Decedent's Name (First, Middle, Last)	- D D 1	-		Date of Deat Month	Dav	Year	ne of Death
	Physici /Medic			R. Bernady			Februar			:35 A. [™]
	Examin	er	4a. Facility Name (If not institution, give street and num	nber)		or Location of Death imore		4c. County	e Arunde	51
	Francis		5715 Phillips Street 5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthplace (St. Country)	
	Funeral Director		212 36 6474 ^{1⊠M 2□F}	66 Yrs.	Months Days	Hours Min.	(Month, Day, Dec. 30		Marylan	ıd
	pu »		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d Insid	de City Limits
	show ed at	ō		Baltim						Yes 2 No
	28e-1	rect	Maryland Anne Arundel 10e, Street and Number	Darcin	10f. Zip Code		1	0g. Citizen of W	/hat Country?	
	within 72 hours after death with the Maryland ane. than "neturel", or Items 23a or 28e-f show the Maded Examinatinal be notified at	Funeral Director	5715 Phillips Street		212	225		U.S.		
	death	ner		dent Ever in U.S. 13	B. Was Decedent of I	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American India k, White, etc.	in,
36	or Ite	J. F.	1 ☐ Never Married 2XX Married 1 ☐ Yes If Yes, Giv	2 St No	1 ☐ Yes 2 ☑ No		,		White	
5-0036	hours turel',	ed by	3 Widowed 4 Divorced Year or Da		cedent's Usual Occu	nation		16b. Kind of Bu		
7	in 72	olete	(Specify only highest grade completed)	(Giv	ve kind of work done DO NOT use retire	during most of work	ing	rob. King of Do	on lood in dustry	
2121	filed within Hygiene. other than ent, the Ment	Completed	Elementary/Secondary (0-12) College (1 2 yea.	rs Co	nstructio	n foreman		Miller	nium Che	em.
	be file tal Hyg d othe event,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam			e)	
yla	should be and Mental marked o	70	Walter R. Bern				hie Holy		21-1- 7'- 0-d-1	
Maryland	12 sho h and 7 Is ma trauma		19a. Informant's Name/Relationship (Type, Print) Linda Bernady/ Wife		Phillips	tand Number or Rur			aryland 2	21225
	1 and Health tem 27		20a. Method of Disposition	20b. Place of Dis	position (Name of		-		City or Town, Sta	
nor	Pages nent of int: If it		1 XBurial 2 ☐ Cremation 3 ☐ Removal from 5 '4 ☐ Donation 5 ☐ Other (Specify)	state	rematory or other pla ill Cemete		2005	Baltimo	ore, Mar	v1and
Baltimore,	- F 25		21. Signature of Funeral Service Licensee		22. Name and Addr				rvice, P	
ä	Depare Impor any ir		1 Desame 3 romers			hie Highwa	y Bal	timore,	Marylan	
1			23a. Part 1 Enter the disease, or complications that c shock, or heart failure. List only one cause on e	aused the death. Do not each line.	enter the mode of dy	ing, such as cardiac	or respiratory arre	∋st,	Approx Interva	ximate al Between
	Pnysician		Immediate Cause (Final disease or condition		ALI		CTIC		Onset	and Death
	/Medical Examiner	Н	resulting in death) Due to (or as a consequence of):	- N	1	T	.0000	- ,-	1/21/201
В	w.	-	Sequentially list conditions, b. Due to (OKON P or as a consequence of):	12/	ARTEK	1	ISCAS	E 5,	127001
	nsit	Ical Examiner	cause. Enter Underlying Cause (Disease or injury	DIAKETS	5 M21	LLITU.	TYI	P5 TT	14	LYZAQS
, ć	execu n and ial-tra	Exal	that initiated events C.	or as a consequence of):						1200
8760,	ate be executed hysician and the burial-transit	cal	d						_	
9	leath certificate be executed attending physician and I for use as the burial-transit	Med	IF FEMALE:			-	-	T		
Вох	death ce e attendi	Physician/Med	23b. Was decedent pregnant		Bectopic pregnanc	су		23d. Date Mor	e of delivery hth Day	Year
0	the a	yslc	1 Yes 2 No 4 Pregn 9 Unknown 9 Unknown		5 ☐ Other (specify) _					
۵.	res that the d igned by the be detached		Part II. Other significant conditions contributing to de	eath but not resulting in the	underlying cause g	ven in Part I.	23e. Did tol	pacco use contr	ibute to the cause	e of death?
rds	requires een sign nould be	d b	OBESITY				1 □ Ye	es 2 🗆 No	3 Probably	4 Sunknown
Records,	> 0 0	Completed by	HYPERTENSION)			24a. Was a	n 24b. V	Vere autopsy find	lings available
Re	0 - 0	mo	CHIZONIC REN	AL FA	LURE		perform	ned?	leath?	
Vital	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?			26. Place of Dear	h (Check only on	e)		
of V	d is	ို	1 ☐ Yes 2 No Hospital: 1 ☐ I	npatient 2 ER/Outpat	IBUT 2 DOV	ther: 4 Nursing Ho		ence 6 Othe		
on c	ng fter ne	lon:	Valual 3 1 ording	of Injury h, Day Year) 28b. Time Injury	y Wo	ork? ☐ Yes 2 ☐ No	28d. Describe ho	ow injury occurr	90	
Division	Attending r death. sctor: After y the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place	of Injury - At home, farm,		-	28f. Location (Si	reet and Numb	er or Rural Route	Number,
Ρ	after after Dire	Certification;	4 Homicide determined buildi	ng, etc. (Specify)			City or Town	n, State)		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier Certifying Physician: To the (Check only one) (Check only one)	asis of examination and/or	eath occurred at the investigation, in my	time, date and place, opinion, death occur	and due to the cred at the time, d	ause(s) and ma ate and place, a	nner as stated. and due to the car	use(s)
	within To th compl	Me	29b. Signature and title of contifier		29c. Licer	nse number	2	9d. Date signed	(Month, Day, Ye	ar)
	(_		1 Ruchard 2	1	1D D	0251	9 1	EBRUA	Ry 7	2005
	12		30. Name and address of person who completed caus	e of death (Item 23a) (Typ	pe, Print)		GLEN	12. ~	M	2011
	`		PICHARD (18	HEIZ (R	AIN 10	WE125	GLEN	100/21	012 111	2106
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. R FEB 0 9 2005	egistr s Signature	Aprile	,				

State of Maryland / Department of Health and Mental Hygiene 0 0 5 03842 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** David Wilson Brown 10:25A M 31 2005 Jan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A 3708 Glen Avenue If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 219-40-1277 XXM 2□ F 63 Yrs Director 31,1942 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits itam 27 is marked other than "natural", or itams 23a or 28e-f ehow other traumatic event, the Madical Examinar must be notified at N/ABaltimore Maryland 1 Yes 2 □ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21215 3708 Glen Avenue USA deeth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. a filed within 72 hours efter I Hygiene. other than "natural", or ita 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black þ Specify. 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Merchant Marine 12th grade Seaman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Deportment of Health and Mental Hy important: if item 27 is marked oth any jury or other traumatic event 2008. Murty Dunton Lewis Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 830 Lenton Ave Baltimore, Maryland 21212 Lynette T. Brown-Hill 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2/5/05 Zion Cemetery Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 23a. Pant Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

A Cutto 5240 Reisterstown Rd Baltimore, Md 21215 Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and the burial-transit the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate has 1 ☐ Yes 2 ☐ No 2X No 1 ☐ Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🟲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D20215 4419 Palls Roch, BottineRa, MS 21211 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. NOIR, MO KARMA. 3 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 9 2005 Registrar

			1- For State of Maryl Registrar		artment of I			iene g. No. 20	05	03843
	Physici /Medic		1. Decedent's Name (First, Middle, Last) RUTH BUCHW	IALD	Lu. 02. 7			Y 5, 200		3. Time of Death 6:55P M
	Examin	er	4a. Facility Name (If not institution, give street and number) MANOR CARE	to a black to 1		SVILLE If Under 24 Hrs.		4c. County o	BALT	IMORE
	Funeral Director		5. Social Security Number 213-10-6041 Usual Residence of Decedent	yrs. last birthday) 90 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 3-9-1	Year) 914	Country	ce (State or Foreign y) YLAND
	Maryland 1-1 show Ilieu at	tor		. City, Town or Lo	ocation	ROS	EDALE		10d	Inside City Limits 1 ☐ Yes 2 ☒ No
	h with the	Funerai Director	10e. Street and Number 7908 31ST STREET		10f. Zip Code	1237	1	Og. Citizen of Wh	nat Country	1?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If itam 27 is markad other than "natural", or Itams 23a or 28a-f show myn jnury or other traumatic avant, the Modical Exertif or matter inclified at ance.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of his Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American White, etc	
21215-0036	ad within 72 h rgiene. ar than "natu t, tre Modical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire HOMEMAKE	during most of worked)	ing	16b. Kind of Bus	HOME	stry
Maryland	2 should be filed withir and Mental Hygiene. Is markad othar than aumatic avant, I'e M	To Be (17. Father's Name (First, Middle, Last) CHARLES BIRMINGHAM			18. Mother's Nam PEARL		Maiden Sumame, GENSTEIN		
	1 and 2 sho Health and am 27 is mu ither traums		19a. Informant's Name/Relationship (Type, Print) HELEN BUCHWALD/ SISTER-IN-LA	₩ 5817	CARRING	I and Number or Rur	BALTIM	ORE, MD	2116	52
Baltimore,	Pages 1 nent of He ant: If itar ury or oth		1 Removal from State		sition (Name of natory or other pla	ce)	0-2005	BALTIMC	·	
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	_		ess of Facility CVA		DALE FUN ALE, MD	IERAL 2123	
	Physician		23a. Part1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	leath. Do not ent		ng, such as cardiac	or respiratory arre	est,	l In	pproximate Iterval Between Inset and Death
	/Medical Examiner		resulting in death) Due to (or as a con	sequence of):	,					
) A	scuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the cond	teo L	Sons					
68760,	icate be executed physician and s the burial-transit	icai	Due to (or as a conduction of the conduction of	sequence on:	m 1	ractions	No.			
P.O. Box 6	The law requires that the death certificate be executed ste has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 ☑ No 9 □ Unknown	etal death 3	Ectopic pregnanc Other (specify)	у		23d. Date Month		ay Year
ecords, P.	w requires that i been signed by should be deta	by	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.		acco use contrib s 2 \(\text{No} \) 3	ute to the	
α	: The law recate has been, page 2 sho	Completed		_			24a. Was ar autopsy perform 1 Tyes 2	pried?	or to comp ath?	r findings available letion of cause of
of Vital	Physician: Th this certificate ral director, pag	To Be		2 ER/Outpatien	t 3 DOA Ott	26. Place of Deat	me 5 Reside	nce 6 Other		
Division	ding After fune	Certification:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		Wo M 1□	rk? Yes 2 □ No	28d. Describe ho			In the Advantage
Divi	oital or At urs after o ral Dirac		4 Homicide determined building, etc. (Sp	ecify)		4	28f. Location (Str City or Town	, State)		
	To tha Hospital or Attani within 24 hours after deatl To the Funaral Diractor: completely filled in by the	Medical	29a. Certifier (Check only one) 2 Madical Examiner: On the bast of my and manner stated.			opinion, death occur	red at the time, da		d due to th	e cause(s)
	To wit		person	MD	D	31464		2/8/	105	
	1,8		30. Name and address of person who completed cause of death (ltem 23a) (Type,	Print) , EUTAV	v St Smt	£ 308, 1	Baltin	n n	ND 21201
	Sta Registr	-	31. Date filed (Month, Day, Year) Registrar's S	the April	de	_				

			1	Please	State of M						-		_	
			1 _ State		State of M	arylar		rtificate o				_	2005	03811
			Registrar 1. Decedent's Name (First	Middle 1	aet)	0		Timeate o	Dea		2. Oate of De	Reg. N	<u>~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ </u>	3. Time of Death
	Physici	an	Docic	, 14110070, 20	Riv	-10					Month	Di	Year	or 8:45PM
	/Medio Examir		4a. Facility Name (If not in	stitution, giv	ve street and number)	10	<u> </u>	4b. City, Town	, or Locat	tion of Death		40	c. County of Dea	ith 0 1 1
1	Examin	er	Mariner	_	Health			Gler	B	urn	P		Anne	Arundel
	Funeral		5. Social Security Number		'		last birthday)	If Under 1 Ye Months Day	ar II Ur	nder 24 Hrs.	8. Date of Bir (Month, Da 11-15-	th	9. Bi	thplace (State or Foreign ountry)
	Director		217-20-0330		1□M 2ਊF	78	Yrs.				11-15-	1926	b Man	yland
	and		Usual Residence of Deceded	County		10c. Cit	ty, Town or Lo	ocation						10d. Inside City Limits
	Mary!	ō	MD Ann	ne Aru	ındel	G1e	n Burr	ie						1 ☐ Yes 2 ☑ No
	28e	rect	10e. Street and Number					10f. Zip Code	•			10g. C	itizen of What C	ountry?
	s 1 and 2 should be filed within 72 hours atter death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23s or 28e-f show other treumatic event, it a Medical Evant are must be rectified at	by Funeral Director	101 Three Co	oin Wa	ay #201			2106	0			U.S	S.A.	
	deat ems	ner	11. Marital Status		12. Was Decedent Armed Forces	Ever in U	.S. 13.	Was Decedent of	f Hispanio	c Origin? (Sp xican, Puerto	pecify Yes or No)-	14. Race - Am Black, Whi	
9	atter or Ite	Fu	1 Never Married 2	_	1 ☐ Yes 215			1 ☐ Yes 2 ☐ X		city:	, , , , , , , , , , , , , , , , , , , ,		Specify: Wh	
9	urel',	d b	32€ Widowed 4 □ D		Year or Dates:		100 Dave	danda Haval Os				105		
5	n 72 "nat	Completed	(Specify only	ecedent's E y highest gr	rade completed)		(Give	dent's Usual Oci kind of work do DO NOT use ret	red) red)	most of work	king	160.1	Kind of Business	vindustry
12	withi iene then	E	8 Elementary/Secondary	(0-12)	College (1-4or	5+)	Clerk		ŕ			Ret	ail	
d 2	illed Hygid other	Be C	17. Father's Name (First, I Henry Keifer	Middle, Lasi	t)						e (First, Middle		n Sumame)	
lan	should be fand Mental be marked of umatic sve	To B	Henry Keller						Kat	nerin	e Kable	r		
Maryland 21215-0036	2 should be filled within and Mental Hygiene. Is marked other then eumatic svent, the Me		19a. Informant's Name/Re	elationship	(Type, Print)		19b. Maili	ng Address (Stre	et and Nu	umber or Rui	ral Route Numb	er, City	or Town, State,	Zip Code)
	ss 1 and 2 of Health item 27 I		Michael Burf		Son	- 1							nie,MD	
ore	Pages 1 nent of H ant: If iter ary or oth		20a. Method of Disposition 1 ☑Burial 2 ☐ Cren		☐Removal from State	20b. F	emetery, cre	sition (Name of matory or other p	lace)	1	Date		ocation - City or	
Ë			4 □ Donation 5 □ C	ther (Speci	ify)	Lak		Memori	1.00		-9-2005	Syk	esville	, Md
Baltimore,	permit. Page Department o Importent: If any injury or once.		21. Signature of Functial S	Service Lio	LMA		Ą	Mbrose	ress of F Funer	acility :al Hoi	me, Inc	1 1	itus, MD	01007
	40274		23a. Part1. Enter the dise	ASP OF COR	nolications that cause	d the deat							itus, MD	Approximate
			shock, or heart failur Immediate Cause (Final	re. List only	one cause on each I	ine.			^					Interval Between Onset and Death
4	Physician /Medical		disease or condition resulting in death)		a. Due to (or as	3/	4 1 1000011	nhAR	12	eerm	INC			
	Examiner			- 1	API		SCLE	20575	*					
		Je.	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	s, ite	Due to (or as									
	cuted	Examiner	that initiated events	•	c									
760,	ite be executed sysician and ne burial-transit		resulting in death) Last		Due to (or as	a conseq	uence of):							
6876	cate b	dlcal		•	d									
9 x	ding p	/Me	IF FEMALE:		23c. If yes, outcome	of pregna	ancv						23d. Date of de	liven
Вох	atten for us	clan	23b. Was decedent pregring in the past 12 month		1 ☐ Live birth 4 ☐ Pregnant a	2 🗌 Feta	Ideath 3	∃Ectopic pregna ∃ Other <i>(specify)</i>					Month Month	Day Year
P.O.	that the death certiticate ed by the attending phys detached for use as the	Physician/Med	1 □ Yes 2 □ No 9 □ Unknown		9□ Unknown		_							
	uires that signed b d be deta	y P	Part II. Other significant of				ulting in the u	nderlying cause	given in P	art I.	23e. Did t	obacco	use contribute t	o the cause of death?
rds	w require been sig should b	ed b	DEMENT	14 -	- VASCUI	AL					10	Yes 2	!□No 3□P	robably DUnknown
ပ္သ	Physicien: The law requires that the death certiticate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	Completed by	RHEUMA	(Der	やいまし	MS					24a. Was		24b. Were a	utopsy findings available completion of cause of
Ä	The law	mo	CHROML	Office	TRUCTUO	or	LHUNN	Arly Dr	58-45	T-		rmed? 2⊠ No	death?	
ita	icien: Th certificate rector, pag	Bec	25. Was case referred to examiner?		-	-				Place of Deal	th (Check only o	опе)		
of V	hysic his co	은	1 ☐ Yes 2 ☐ No		to the second		ER/Outpatier	II 3 DOA		Nursing Ho			6 □Other (Spe	ecify)
Ē	ing P	on:	27. Manner of Death 1 Natural 5	Pending	28a. Date of Inju (Month, Da	iry ly Year)	28b. Time o Injury	٧	lork?	a □ No	28d. Describe I	how inju	iry occurred	
sic	ttend death ttor: / the f	cat	2 Accident 3 Suicide 6	investigation Could not to	be 200 Blood of In	ium. At h	ome form et		☐ Yes	2 🗆 140	28f Location /	Street a	nd Number or A	ural Route Number,
Division of Vital Records,	or A	Certification;	4 Homicide	determined	building, e	c. (Specif	y)	eet, lactory, ollic			City or To			
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely tilled in by the funeral director.	C			hysician: To the best									
	n 24 h	Medical			miner: On the basis of and manner st	f examina								
	To the To the To the Comp	M	29b. Signature and title of		-				nse numb			29d. Da	ate signed (Mon.	th, Day, Year)
			▶ VOL	no	m 25_			2)/7	113		8	18/00	
1	16		30. Name and address of	person who	completed cause of	death (Item	23a) (Type,	Print)	5 .	B1	-112 × 1		0 40 0 1	136
) '		31. Date filed (Month, Day	(TTTL	32. Regis	ar's Signs	uture	society ?	A	MU	114014	7	10000	143
	Sta Registr			B 0 9	2005	nu o olyild	K	South						
				ט ס	LUUU JUE		100							

DHMH 17 Rev 1/2001

5:50

2005

2

FEBRUARY

THERESA

BROCCOLINA,

ORIGINAL

			For State Registrar		State	of Maryla	and / Dep. <i>Ce</i>	artmen rtificate				lental Hy	giene Reg. No.	. U U	5	038	346
	Physici	an	Decedent's Name (First, Management)	fiddle, Las	t)							2. Date of De Month	ath Day	Y	/ear	3. Time of	
	/Medic	al	Jo Ann Beck 4a. Facility Name (If not insti		atract and n	umbor)		4h Cihr	Town or	Location	of Doath	February		2005 County of	Death	3:55 F	P [™]
	Examin	ier	Harford Memoria			uniber)		Havre			OI Death			Harfor			
ī	Funeral		5. Social Security Number	6. Se	x		rs. last birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da				lace (State o	or Foreign
ı.	Director		213-66-7744		⊒м 2 Д (F	49	Yrs.	NOTIFIS	Days	riours	141111.	December	26,	1955	Mary		
	land Dw		Usual Residence of Deceder 10a. State 10b. Co			10c.	City, Town or Le	ocation							10	0d. Inside C	ity Limits
	Many Ff sh	to	Maryland Har	ford			Abendeen	า								1 🗌 Yes	2 X No
	th the	irec	10e. Street and Number					10f. Zip	Code				10g. Citi	zen of Wh	at Coun	try?	
	ath wi	rai	1926 Park Beach I	Prive					.001					SA			
36	d within 72 hours after death with the Maryland jiene. Ir than "natural", or Itams 23a or 28a-f show It a Madical Exactlished at	by Funeral Director	11. Marital Status 1 □ Never Married 2X 3 □ Widowed 4 □ Divo		Armed F	2 XX No		Was Deced If Yes, spec 1 ☐ Yes 2	ify Cuba	ispanic Ori in, Mexicar Specify:	n, Puerto	ecify Yes or No Rican, etc.)		14. Race - Black, Specify: N	White, e	etc.	
2-0	72 hou	ted	15. Dec (Specify only h	edent's Ed)		dent's Usua kind of wor			at of worki	ina	16b. Kii	nd of Busin	ness/Ind	lustry	
21	withln ene. than "	Completed	Elementary/Secondary (0-			(1-4or 5+)	life.	DO NOT us	e retired)		9	T-1-		0-		
2	filed v I Hygie other t		17. Father's Name (First, Mic				Clerica	11		18. Mothe	er's Name	(First, Middle	-	phone Sumame)			
an	ld be ental ked o	To Be	Mancil Crouse						}	Kathr	~yn Tu	rner					
ary	2 should be and Mental is marked eumatic ev	-	19a. Informant's Name/Rela	tionship (T	ype, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Aura	il Route Numb	er, City o	Town, Sta	ate, Zip	Code)	
Σ,	is 1 and 2 of Heelth a Item 27 is other tree		Francis E. Beck,	Jr. /	/ Father					rive		leen Mary					
lore	Pages 1 and 2 should be filed hent of Heelth and Mental Hyg int: If Item 27 is marked othe iry or other treumatic event,		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crema	tion 3 🗍	Removal from	State	b. Place of Dispo cemetery, cre	matory or o	ther plac			Date		cation - Ci	•		
Baltimore, Maryland 21215-0036	rtmer rtant		*4 Donation 5 ☐ Oth 21. Signature of Funeral Se			U tina I	ulaney Val	Name an	d Addros	e of Facili	h/	05	Timon	ium Ma	rylar	nd	
Ba	Depermine Depermine any it		Phinton	2		tona .	iii wii	eonard 305 Ha	J. R rtord	uck, 1 Road	ĺ'nc Bålt	imore Ma	rvlan	d 212	14		
			23a. Part1. Enter the diseas shock, or heart failure.	e, or comp	lications that	caused the d						or respiratory a	rrest,			Approximat Interval Bet	tween
	Priysician		Immediate Cause (Final disease or condition	10000	а.	GANG	RENOUS		SMX	326	BUZ	WEL				Onset and	Death
	/Medical Examiner		resulting in death)		Due to	(or as a cons	RENOUS sequence of): OCCIO	1101010		1011-0	25-11-1	E010	1 h	1= 1 m	20 71	,	15/
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		b. Due to	(or as a cons		COLVO		1000	CNI	CICIE	110	1000	100	1 /	
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	1	C												
Ö,	cate be executed obysicien and the burial-transit		resulting in death) Last			(or as a cons	sequence of):										
8760,	physic physic the b	dica		•	d										+		
O. Box 6	death certif	Physician/Medical	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	it		birth 2 ☐ F mant at time o	etal death 3	⊒Ectopic pri ⊒ Other (sp					2	3d. Date of Month		•	Year
α.	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant co				_	nderlying ca	ause give	en in Part I		23e. Did t	obacco u	se contribu	ute to the	e cause of c	death?
rds	w requires been sign should be				NIB							1 🗆 '	Yes 2	□ No 3[☐ Proba	ably 4 DI	Unknown
eco	ne law requ n has been ge 2 shoul	piet	SI	TACC	+1 AR	60 F	outl	OBSTA	lile	7100		24a. Was autor	SV	24b. We	re autop	sy findings apletion of c	available ause of
Vital Records,	Pe e	Completed	Ch	ROIL	Amos	OF 1	HERBTI	Č F	LEXE	UKE			rmed? 2 No	dea 1 🗆	th? Yes :	2□ No	
Vita	ding Physicien: Th n. After this certificete funeral director, pec	Be	25. Was case referred to me examiner?	H	Hospital:	/			Othe			(Check only o					
of		.: To	1 Yes 2 No 27. Manner of Death		1 🗠	Inpatient 2 of Injury nth, Day Year	2 ER/Outpatie		8c. Injury Work			me 5 Resident)	
ion		atior		ending vestigation		nth, Day Year	r) Injury	М		k? Yes 2□	No						
Division of	5 to 5	Certification;	3 ☐ Suicide 6 ☐ C	ould not be stermined	286. Plac	e of Injury - A ding, etc. (Sp	kt home, farm, st ecify)	reet, factory	, office			28f. Location (: City or To			or Aurai	Route Num	nber,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edicai	(Check only 2 Med one)	lical Exam	iner. On the		knowledge, deat nination and/or in						date and	place, and	d due to	the cause(s	5)
)	To t To t	Σ	29b. Signature and title of the	o Militier W	elX		MD		D	253	597		٥	signed (A	105	_	
_	10		30. Name and address of pe	CANZ	A.S. 1		015.0	Print) ViCiV	Ave	2 F	HAVE	e de (GRA	CE, M	10.	2107	18
• •	Sta Registr		31. Date filed (Month, Day,	9 9 7	32	gistrar's Si	gnature	-	6								
	MH 17 Rev 1/2	åw.		y (/	-06000	11 19		,								

215/05 1555 PM

	•	For State	State of Maryland		artment of F		nd Men	tal Hygiene	005	03847
_		Registrer 1. Decedent's Name (First, Middle, Las	st)		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Date of Death		3. Time of Death
Physici		Daniel B	i Druz					Month Day	Year 2005	0055 AM
/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of			County of Death	h
	•	Worthwest	HAM: Kest		Randy	licton	41		Button	lose
Funeral		5. Social Security Number 6. S			If Under 1 Year Months Days	Hours	4 Hrs. 8. I	Date of Birth Month Day Year) 0V.5,1916	9. Birth Co.	nplace (State or Foreign untry)
Director		220-09-8449 Usual Residence of Decedent	X ^{M 2□ F} 88	Yrs.			N	74.5,1910		NY
land ow		10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits
Mary Hah	ţ	MD BALTI	MORE	PIKE	SVILLE					1 ☐ Yes 2 🂢 No
r 288	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Co	untry?
death with the Maryland ms 23e or 28e-f show rmst be notified at		4001 OLD COURT	ROAD #109			2120	8			USA
r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origi an, Mexican,	in? (Specify Puerto Rica	Yes or No-	 Race - American Black, White 	
ETZ IS-UUSO Within 72 hours after death with the Marylar Jiene. I then "natural", or items 23e or 28e-1 show The Modical Examinat must be notified at	by F	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:			Specify:	WHITE
P hour		15. Decedent's Ed		16a. Deced	ient's Usual Occup	ation		16b. Kir	nd of Business/l	industry
nin 72	plet	(Specify only highest gra		(Give life. l	kind of work done DO NOT use retired	during most (d)	of working			
d with	Completed		4	OWNE	R			LIQ	UOR STO	RE
naryland 2 2 should be filed v o and Mental Hygie 1s marked other t reumatic event, th	Be (17. Father's Name (First, Middle, Last)		D.T.E.D.	-		•	rst, Middle, Maiden	Surname)	CHADIDA
aryian should k ind Ment s marked umatic	ဂ္	IRVING		BIER		ANN				SHAPIRO
2 short and less mereum		19a. Informant's Name/Relationship (RUTH BIERER / W	Туре, Print) IFE					oute Number, City or PIKES		
OCE, Maryla ges 1 and 2 should t of Health and Men If Item 27 Is marke or other treumatic		20a. Method of Disposition			sition (Name of	KT KOA	Date	-	cation - City or	
DESILITATION DE PERSONAL PAGE 1 Deportment of His Importent: If Iter any Injury or other space.		1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	metery, crer	natory or other plac AEL CEME		2/07/3		BALTIMO	
Salfilmol bernit. Pages Department of mportent: If I tny Injury or o		*4 □ Donation 5 □ Other (Specification 21, Signature of Funeral Service Liber						_EVINSON &		
Department of the partment of		MAINANIX 7	Milon					AD - PIKE		
		23a. Fa II. Enter the disease, or com shock, or heart failure. List only	plications that caused the death.	Do not ent	er the mode of dyir	ng, such as c	ardiac or re	spiratory arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	one cause on each line.	100						Onset and Death
/Medical		resulting in death)	a) Due to (or as a consequent	ence of):	marzi	C. C. SAL				
Examiner		Sequentially list conditions.	b							
P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):						
ecute and I-trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c	ence of):						
cate be executed cate be executed physician and the burial-transit	cal E		,	•						
DO/ filicate g phys	D		. 0							
. BOX 68/01 death certificate be attending physicis d for use as the bu	lan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnant		Ectopic pregnance			2	23d. Date of deli	*
	sicla	in the past 12 months? 1 \(\sum \text{Yes} 2 \sum \text{No} \)	4 Pregnant at time of de		Other (specify)	y 			Month	Day Year
ords, F.C. I	Physicia	9 🗆 Unknown								dia anno af danta
dS, T	by	Part II. Other significant conditions of	contributing to death but not resul	ting in the u	nderlying cause giv	ren in Part I.		4.		the cause of death?
COLDS W requires been sign should be	ted					-		-		
e law has b	Completed							24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
VITAI KEC slcien: The law s certificate has t lirector, page 2 s								1□ Yes 2□4No	1 🗆 Yes	2 No
Of Vital Physicien: 1 this certifical ral director, p	Be	25. Was case referred to medical examiner?	Hospital:	70	ott of	105		heck only one)	COther (Co.	- 4.1
P P P In In In In In In In In In In In In In	To To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	P/Outpatier 28b. Time of	28c. Inju	ry at	_	5 Residence 6		ary)
Attending Phy r death. ector: After thi by the funeral or	tlor	1 Natural 5 Pending 2 Accident investigatio	(<i>Month, Day</i> Year) n	Injury	M 1 □	rk?]Yes 2 ☐ N	lo			
LIVISION I or Attending after death. Director: After	Hice	3 ☐ Suicide 6 ☐ Could not be determined			eet, factory, office		28f.	Location (Street and City or Town, State)	d Number or Ru	iral Route Number,
pivile or Attendous after death pirector:	Certlfication;	4 - Homeles	building, otc. (apasily)						<u> </u>	
Hospitel Hospitel Hospitel Funerel E		29a. Certifier 1 ☐ Certifying Pt (Check only 2 ☐ Medicel Exam	nysician: To the best of my knowniner: On the basis of examinati	rledge, deatl	n occurred at the til	me, date and	i place, and h occurred a	due to the cause(s)	and manner as place, and due	stated. to the cause(s)
DIVISION To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical	one)	and manner stated.		29c. Licens				e signed (Mont)	
5 ₹ 5 g	2	29b. Signature and title of certifier			i ·	11297	7/.	7 /	- J (1 -
1011		30. Name and address of person who	completed cause of death (Item	23a) (Type	Print)	70//	4	freg	1243524	6 Z0PS
(U)		AL' 10 MJ	to wanter	A 1	1. mita	C /1.	1-2	11580 Wa	he so m	land
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure /	1 1:	104	72-4		1	
Regist	rar	FEB 0 9	2005 John	D.	gove					

			For State				epartmen			ind Me	ental Hy		005)	038	48
			1 - State RegistraMEND TT 1. Decedent's Name (First, Midd	EM #19a P	ER FH	G840 2	124/05	JH L	Jealii	2	2. Date of De				3. Time of	
	Physici		Bruce Carey	,						F.	eb. 3	, 200		ar	3:12	РМ
	/Medic Examin		4a. Facility Name (If not institution	on, give street and r	umber)		4b. City,	Town, or	Location of				County of D	eath		
			10820 Antigua	Terrace A				ckvil				M	ontgo			
	Funeral		5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F		yrs. last birtho Yr	Months	1 Year Days	If Under 2 Hours	Min.	Month, D	ay, Year)	9.		ce (State o	
	Director		220.46.4198 Usual Residence of Decedent		55		<u>. </u>			IJ	an. 31	1, 19	50 Wa	asnı	ingtor	ı, DC
	yland how		10a. State 10b. Count	y	10	c. City, Town o	or Location							100	d. Inside Cit	
	Se-1 s	ctor		gomery		Rockvil	1e								1 ▼ Yes	2 □ No
	Vith th	Dire	10e. Street and Number				10f. Zip						zen of What	Countr	y?	
	eath v	eral	10820 Antigua		pt. 20			0852	ispanic Orig	in? (Speci	ify Yes or No	US	A 14. Race - A	mericar	n Indian	
·0	riter d	Funeral Director	1 ☑ Never Married 2 ☐ Ma	Armed I arried 1 ☐ Yes	Forces? 2 ⊠ No	0.0.	13. Was Deced			Puerto Ri	can, etc.)		Black, W	hite, et	c.	
e O	within 72 hours after death with the Maryland ene. Than "neturel", or items 23e or 28e-f show the Madical Exantinal must be notified at	þ	3 Widowed 4 Divorce	od If Yes, C Year or	Dates:		1 ☐ Yes	2 txt No	Specify:				Specify:	Whit	te	
2-0	"netu	Completed		ent's Education est grade completed	f)	(0	ecedent's Usua Give kind of wo	rk done a	during most	of working	7	16b. Kir	nd of Busine	ss/Indu	stry	
12	within ene. than	duic	Elementary/Secondary (0-12)	College	(1-4or 5+)	1	fe. DO NOT us	•)							
0	filed v Hygie other i	Be Co	17. Father's Name (First, Middle	e, Last)	4	J0	urnalis	SL	18. Mother	r's Name (First, Middle	, Maiden	Sumame)			
lan	uld be Aental rked o	To B	Tony James	Carey					M	Maril	yn Sch	warz				
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene 1 steurer; or flems 23e or 28e-1 show item 27 is marked other than "neturer; or flems 23e or 28e-1 show other treumatic event, the Madical Examinar main he notified at	•	19a. Informant's Name/Relation	ship (Type, Print)			Mailing Address									0.50
	l and lealth im 27 her tr		Marilyn Berdan 20a. Method of Disposition	ski Mo	ther		20 Anti		Terra	ace A			ckvil. cation - City			852
Dor	Pages nent of H int: If ite		N Burial 2 ☐ Cremation	3 Removal from	(cemetery	crematory or o	ther place	ey 02	2/06/2			s Chui			
altimore,	permit. Pages Department of Importent: If i any injury or once.		' 4 Donation 5 Other (21. Signature of Funeral Service				22. Name an			Tose	nh Gav					
Ba	Dep Imp		Vaus &	1-	MO13	78	5130 W				-)
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	complications that st only one cause on	caused the	death. Do not	enter the mod	e of dying	g, such as c	cardiac or i	respiratory a	rrest,		lr Ir	oproximate	veen
Š.	Physician		Immediate Cause (Final disease or condition	a Mu	Hin	le n	14elo	md							Onset and D	eath
	/Medical Examiner		resulting in death)	Due to	o (or as a co	nsequence of)										
Ы		0	Sequentially list conditions, if any, leading to immediate	b. — Due to	o (or as a co	nsequence of)	:									
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<	,											
ó	an and rial-tra	Еха	resulting in death) Last	cDue to	o (or as a co	nsequence of)	*									
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and lage 2 should be detached for use as the burial-transit	dical		d												
	eath certific attending p	/Mec	IF FEMALE:	23c. If yes, o	utcome of n	regnancy										
Вох	eath c attend for us	clan	23b. Was decedent pregnant in the past 12 months?	1 Live		Fetal death	3 ☐Ectopic pr 5 ☐ Other (sp					2	3d. Date of o Month			ear
0	that the de led by the a detached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unk												
S, D	es that igned to be det	by P	Part II. Other significant condit	tions contributing to	death but no	ot resulting in th	ne underlying ca	ause give	en in Part I.		23e. Did t	obacco us	se contribute	to the	cause of de	ath?
ecord	w require been sig should b				-						10	Yes 2	<u> </u>	Probab	ıly 4 □Uı	nknown
ecc	e law r has be ge 2 sh	Completed								_	24a. Was	osy	prior 1	o comp	y findings a letion of ca	vailable use of
-											1 Yes	2 No	death 1 🗆 Y		D MC	
Vital	ysicien: The sistem of the contilicate director, pag	o Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital:	Inpatient	2 □ EP/Outor	atient 3 DO	Othe	ar.	of Death (Check only o		□Other (S	200(44)		
o	g Phy er this eral d	-	27. Manner of Death	28a. Dat	e of Injury onth, Day Ye	28b. Tim	e of 2	8c. Injury Work	at		d. Describe			Decity)		
Ö	Attending F death. ctor: After y the funer	atio	Z / TOOTGOTTE	tigation	nui, Day 19	<i>ar)</i> Inju	M		r Yes 2 □ N	lo						
Division	or Atte ter de irecto n by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	mined 286. Place	e of Injury - ding, etc. (S	At home, farm pecify)	, street, factory	r, office		281	f. Location (. City or To		Number or	Rural F	Route Numb	er,
	pitel o		20a Carrifice 18 Carrific	ing Obveisions To the	no host of m	u kaandadaa d	looth converse			l alaca, car	d due to the	(-)				
	To the Hospitel or Attending Physicien: whith 24 hours after deals are the Funeral Director; After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certify (Check only 2 Medice one)	ing Physicien: To the I Exeminer: On the and ma	basis of exa nner stated.	mination and/o	or investigation,	in my op	oinion, death	n occurred	at the time,	date and	place, and d	ue to th	ed. ie cause(s)	
}	To the within To the Complete	Me	29b. Signature and title of certifi	er	1	·11 .		. License				29d. Date	signed (Mo	nth, Da	y, Year)	
	7		· Patricia	10msp	Ro 1	May,	mo	Di	5/9/	6		te.	b. 3,	, 2	Vac	7
	20		30 Name and address of person	n who completed car	use of death	(Item 23a) (Ty	pe, Print)	D-1.	0	-100	D	Li	1/- 1	nn	100	>=>
	- 04		31. Date filed (Mpm) Pay. Kea	0 Vay	egistrar's	Signature	VIIIE	FIKE	r, 6	1mj	100	NVI	114,1	11U	200) d
	Sta Registr		31. Date filed (Month, Bay, Yea	2005	Selva.	K.	parte									

State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 054 M AMRS plo NA 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. AI (en-5. Social Security Number 210.09.0020 If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Davs Hours Min. **™** M 2□ F 84 Johnstown, Director Jan.16,1921 Usual Residence of Decedent with the Maryland 10b. Count 10c City Town or Location 10d Inside City Limits 10a State ir than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at MD 1 XYes 2 ☐ No Prince Georges Silver Spring Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3144 GraceField RD 20904 United States Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Electrical Engineer Westinghouse Electric other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) if Health and Mental Item 27 is marked o Joseph James Carr Clara Eschement 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20016 5730 MacArthur Blvd, N.W., Washington DC David Carr Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 0 = 1 X Burial 2 Cremation 3 Removal from State ŏ permit. Page Department of Important: If any injury or once. Restland Memorial Park 2/4/05 1 4 ☐ Donation 5 ☐ Other (Specify) East Hanover, NJ 22. Name and Address of FacilityJoseph Gawlers Sons Inc. 5130 Wisconsin Ave. N.W., Washington DC 20016 23a Part1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Subdural hematoma weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical the as IF FEMALE: been signed by the attendin should be detached for use MAKER Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Ö 9☐ Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given of the last 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 No 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification; To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No UNK FAI December Japas 2 Accident investigation hours efter death. 6 Could not be determined Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide Residence MG PACEFIELD LISTER Sping Marylul within 24 hours e To the Funeral C completely filled 1 🗌 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AV4176435R13038 Feb 01 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amber Ress-Hold mD 2120 Si Coceno St. 31. Date filed (Month, Day, Year) sistrar's Signature State FEB 0 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 6, 2005 **Physician** 1:39 P M Anthony Carpintieri /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie 7466 Furnace Br. Rd. Apt. 425 Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. Oct. 3, 1930 9. Birthplace (State or Foreign Country) Mary Land 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 213-28-1382 74 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location nial Hygiene. so other than "natural", or lieme 23e or 28e-f shov event, the Medical Examinar must be notified at 1 ☐ Yes Ž☐ No Director Maryland| Glen Burnie Anne Arundel 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code death with 21060 7466 Furnace Branch Road Apt. 425 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1とYes 2 No Army Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on and of Health and Mentat Hygiene.
ant: If Item 27 Is marked other than "natural", or Itee ury or other traumatic event, Ite Medicial Examination 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: lf Yes, Give Year or Dates: Korean Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automotive Repair 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosaria Maggio Guisepe Carpintieri 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 Grisham Court, Bel Air Maryland 21014 Dorothy Ford - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) February 10 20c. Location - City or Town, State 20a. Method of Disposition 1 X urial 2 □ Cremation 3 □ Removal from State 2005 permit. Page Department of Importent: If sny injury or Baltimore Cemetery Baltimore, Maryland 4 □₫ 5 Other (Specify) ure of Funeral Service Licensee 21. Signal Kirkley-Ruddick Funeral Home P.A. 0 421 Crain Highway S.E. Glen Burnie, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter th disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760. attending physicien Completed by Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed Part,II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 90 3 🗌 Probably 4 Donknown 1 Tes 2 No peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the funeral director, page 2 autopsy performed? Yes 2 No 2 No 1 Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one examiner' Other: 4 Nursing Home 5X Residence 6 Other (Specify) Certification: To 1 Tyes 2 1 HO 1 Inpatient 2 ER/Outpatient 3 DOA this: 27. Mann of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Hospitel or Attending 1 Anatural 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 Accident 24 hours after death Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 29a. Certifier 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only within 2 To the To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number of death (Item 23a) (Type, Print) who completed gause PROFESSIONAL BLDG. SUITE 106 OAKWOOD GLEN BURNIE, MD 21061 31. Date filed (Month Day Bear) 9 trar's Signature State Registrar

CPM 05-00940 ADRIAN CHASE

AN	CHASE		1. State Unpend Item 23	State of Ma 3a-b, pt.I	arylan 1,27	d/Depa per_me	rtment o tilicate	f Health 3–28–0 of Death	and Mo	ental Hy	giene Reg. No.	200	5	038	151
	Dhuaisi		1. Decedent's Name (First, Middle, Last)							2. Date of Dea Month				3. Time of D	eath
	Physici /Medic		Adrian Chase							Februa	ry O	5 , 20	05 [17:00	M
	Examin	er	4a. Facility Name (If not institution, give					n, or Location			4c.	County of De	eath		
			Sinai Hosp 5. Social Security Number 6. Sec		e (In vrs.	last birthday)	If Under 1 Ye	Baltimo Bar If Under		8. Date of Birt	h	9. E	Birtholac	e (State or I	Foreian
	Funeral Director			M 2□F 5		Yrs.		ys Hours	Min.	(Month, Da)	y, Year)	Ma	Couptry ryLa	nd	or orgin
	0		Usual Residence of Decedent						J	J//UO/1	934		140.	1-11-02	
	arylar show	ř	10a. State 10b. County		10c. Cit	y, Town or Lo							100	. Inside City 1 X Yes 2	
	the M	Director	Maryland 10e. Street and Number			Balti	10f. Zip Coo	la .			10a Citi	zen of What	Country		
	with With			A									Country	•	
	death	Funeral	5000 Queensberry 11. Marital Status	12. Was Decedent		.S. 13. V		1215 of Hispanic O	rigin? (Spe	cify Yes or No- Rican, etc.)		S.A. 14. Race - A			
21215-0036	should be filed within 72 hours after death with the Maryland and Menal Hygiene. The Hygiene marked other than "natural", or liems 23a or 28a-f show matic event, it a Medical Examiner must be notified at	by	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 [] If Yes, Give Year or Dates:	No		TYes, specify (rican, etc.)		Black, W Specify:	hite, etc B1a		
Š 2	72 ho	Completed	15. Decedent's Edu (Specify only highest grad				lent's Usual Oc kind of work do		st of workin	ng l	16b. Kii	nd of Busine	ss/Indus	stry	
21	ithin in ith	npie	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. L	OO NOT use re	tired)	or or mornin	_	A 4n	1_1_1	_		
2	led w lygier her th		9			Mech	anic	19 Math	or's Name	(First, Middle,		mobile	9		
anc	ibe fi	Be	17. Father's Name (First, Middle, Last)	,								Sumame)			
Maryland	should nd Men marke umatic	2	Robert Anderson Cl			19b. Mailin	a Address (Str			ris Bry Route Numbe		Town, State	e, Zip Co	ode)	
	nd 2 s alth ar 27 ls r trau		Renee Eggleston /			5000	Oucens	berry	Ave.,	Baltim	ore.	Marv	land	1 2121	5
Baltimore,	os 1 and 2 of Health item 27 l		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name o	f .		ate		cation - City			
E	Pages nent of I int: If its iry or o		1 Burial 2 Cremation 3 F 1 Other (Specify)			-	Cemete		2/11/	2005 1	and	sdowne	. M:	arvlan	nd
alti	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic. ODEs.		21. Signature of Funeral Service Scens	99		22	. Name and Ad	Idress of Facil	lityThe	Derrick	c C.	Jones	F/I	H, P.A	١.
	205 2 3		Mund C-	1		46	ll Park	Hgts.	Ave.	, Balti	mor	e, Mar	ylar	nd_212	215
1	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	lications that caused ne cause on each li a	ne.			dying, such as	s cardiac or	respiratory ar	rest,		- In	pproximate iterval Betwe nset and De	
	/Medical Examiner		rosaling in deality	Due to (or as				lam Dia							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Hyperte	a conseq	uenco of):	LOVASCU	Iai Di	sease						
	te be executed ysicien and te burial-transit	Examiner	that initiated events	c									1		
760,	oe exe		resulting in death) Last	Due to (or as	a conseq	uence of):									
	he he	dicai		d				_					-		
9 xo	death certifical attending phy	/Me	IF FEMALE:	23c. If yes, outcome	of pregna	ancy					,	3d. Date of	delivery		
	0 0 0	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1□Live birth 4□Pregnant at 9□ Unknown			Ectopic pregna Other (specify					Month	Da	ay Ye	ar
<u>Ч</u>	d by the de		9 Unknown Part II. Other significant conditions con	ntributing to death h	out not res	ulting in the ur	adarhina cause	awen in Part	land d	23e Did to	bacco u	se contribute	to the o	rause of dea	ath?
Records,	The law requires that the te has been signed by th bage 2 should be detached.	ed by	Chronic Drug Use	Tributing to dodding				givernin un		1 🗆 Y	١.			ly 4 ∐Uni	
000	aw re	piet								24a. Was autop		24b. Were	autopsy	findings av letion of cau	allable
a B		Completed								1 Ves	med? 2 No	death 1 Z Y	er,	□ No	36 01
<u> </u>	Physiclan: r this certifica ral director, p	o Be	25. Was case referred to medical examiner?	Hospital:	20	ER/Outpatien	2 DOA	Othor		(Check only on ne 5 ☐ Resid			if-()		
Division of Vital	Te e	Certification; To	1	28a. Date of Inju (Month, Da	iry	28b. Time of Injury	28c. I	njury at Work? 1 □ Yes 2 □	2	8d. Describe h		-	рөспу)		
Sic	Attendi death. ctor: A y the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inj	jury - At ho	ome, farm, stre			-	8f. Location (S			Rural R	oute Numbe	э <i>г</i> ,
<u> </u>	after after Dire	ertii	4 Homicide determined	building, et	c. (Specif)	y)				City or Tow	n, State)				
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Exami	sician: To the best ner: On the basis of agrid manner of	£ examina	wledge, death tion and/or inv	occurred at th	e time, date a ny opinion, de	nd place, a ath occurre	nd due to the o	ause(s) date and	and manner place, and d	as state	ed. e cause(s)	
	Nithin Youth	Me	29b. Signature and title of certifier	1	/		29c. Lic	ense number			29d. Date	e signed (Mo	onth, Day	y, Year)	
			· ~ // /	1 V	11		0	.C.M.E			Febr	uary (06.	2005	
1	it give		30. Name and address faerson to co	A - 1 188-	11/0	a) (Type,	Print)								
	Υ		31. Date filed Month, Day, Year)	U. IL IPK	WY A	⊬111 I	enn St	reet, l	Baltin	more, M	aryl	and 21	LZ01		
	Sta Registr		FEB - 9 2005	32. Registr	K	Breek									

Ĵ	00303		1- State of Maryland / D Registrar Amend Item 28a-f per me G841) <u>şpar</u> Cert	rtment of H -05 tas hificate of L	ealth and Death	d Mental Hy	giene	0 =	000000
			Decedent's Name (First, Middle, Last)				2. Date of Dea	ath 👊 🗸	U 0	3. Time of Death.
	Physici /Medio		Johnnie Coffin				January	Day 7 23 21	Year 005	11:06 P.M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of De		7	y of Death	11.00 1.
			458 R Bourbon Street		Havre de			Harf	ord Co	ounty
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birti		If Under 1 Year Months Days	If Under 24 H Hours M	in. (Month, Day	v. Year)	9. Birthp Cour	place (State or Foreign
	Director		240-34-3310	Yrs.			Feb 14,	1935	North	Carolina
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Loca	ation					Od. Inside City Limits
	Mary f sho	5	100 11 5 1		e Grace					1 ☐ Yes 21 No
	the 28a-	rec	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Cour	
	3a or	Ö	458 R Bourbon Street			078			villat Coul	idy:
	death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S.	13. W			(Specify Yes or No-	USA 14. Ba	ce - Americ	can Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I're Medical Examiner roust be notified at ODGE.	by Fur	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	If Y	Yes, specify Cubar □ Yes 2∑ No	n, Mexican, Pu	èrto Rican, etc.)	Bla	ack, White, fy:whit	etc.
21215-0036	hour tural	ed		Docado	nt's Usual Occupa	tion				
5	in 72 n "na	Completed	(Specify only highest grade completed)	(Give kii	ind of work done d O NOT use retired)	uring most of w	vorking	16b. Kind of E	usiness/inc	dustry unk
212	iene.	шo	Elementary/Secondary (0-12) College (1-4or 5+)		mer					
0	Hyg other	Bec	17. Father's Name (First, Middle, Last)			18. Mother's N	ame (First, Middle,	Maiden Sumai	me)	un
Maryland	lid be fenta rked ric ev	ToB	Clinton Coffin							dir
a Z	shound N	-	19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing	Address (Street a	nd Number or	Rural Route Numbe	r, City or Town	, State, Zip	Code)
	alth a 27 lt		and the second s				W Havre d			21078
ē,	of Hei		20a. Method of Disposition 20b. Place of	Disposit			Date	20c. Location		
Ĕ	Page nent (int: If		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 MOther (Specify) in state	,,	nory or outer place	" ! !				
Baltimore,	permit. Departn Imports any inju		21. Si nature of Fineral Service Licensee Wade, Director	St.	Name and Address	s of Facility Dmy Boa	rd 655 W.	Baltin	nore S	Street
			23a. Part1. Ener the disease, or complications that caused the death. Do not	part .	ltimore,		201			
I,			shock, or fleat failure. Elst only one cause on each line.							Approximate Interval Between Onset and Death
	Priysician		Immediate Cause (Final disease or condition resulting in death) Atherosclerotic	Car	diovascu	lar Dis	sease com	licati	ng	Oncor and Bodyn
	/Medical Examiner		Hoda (4) (4) (2) (4) (5) (4) (5) (4) (5) (4) (5) (4) (5) (4) (5) (4) (5) (4) (5) (5) (5) (5) (5) (5) (5) (5) (5) (5	of):						
		-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	Als:						
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury							
	xecu and	xar	that initiated events resulting in death) Last	of):						
3	icate be executed physician and s the burial-transit	alE		·						
58750,	ficate physics from	edical	0.							
×	or Attanding Physician: The law requires that the death certificate be executed the death. Jiractor: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy					22d Da	ate of delive	
ROX	death a atter	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death		ctopic pregnancy Other (specify)					Day Year
л Э	the oy the	hys	9 Unknown							
 J	res that igned b	by PI	Part II. Other significant conditions contributing to death but not resulting in	the und	erlying cause giver	n in Part I.	23e. Did to	bacco use con	tribute to th	e cause of death?
	quire n sig						1 🗆 Y	es 2□No	3 🗆 Proba	ably 4 🐧 Unknown
ဝ္ပ	w requir s been si should	Completed					24a. Was a	ın 24b.	Were autor	osy findings available
Records,	he lav e has age 2	Juc					autops perfor	sy med?	prior to con death?	npletion of cause of
<u>e</u>	il cian ; Th certificate rector, pag	Ö	25. Was case referred to medical			OC Diago of D	1 X Yes		1 X Yes	2 □ No
>	ysician; The is certificate hadirector, page	O B	examiner? 1 \(\overline{\text{Y}} \) Yes 2 \(\overline{\text{No}} \) No Hospital: 1 \(\overline{\text{Inpatient}} \) 2 \(\overline{\text{ER/Outp}} \)	nationt	Othor		eath (Check only or			
Ö	y Phys er this eral di	Η,	27. Manner of Death 28a. Date of Injury 28b. Ti	ime of	28c. Injury	4 Indianing	Home 5 Reside	- 1		At seene
0	tanding Ph death. tor: After th the funeral	atlo	1 □Natural 5 □ Pending 2 Naccident investigation Found 15 □ Found	38 ′ ₽ 1	t _M Work?		Subject	exnosed	to c	old.
DIVISION OF VITAL	Atta	ertification;	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm				29f Location (C	trant and them		Maria Miraha
5	al or s afte	Cert	4 Homicide building, etc. (Specify) Residence				Havre De	Grace	R _D Bo	ourbon St.
	To the Hospital or Attanding F within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and annex stated	death o	occurred at the time stigation, in my opi	e, date and place nion, death occ	ce, and due to the ca	ause(s) and ma	anner as sta	ated.
	To the within 2 To tha complete	Mec	one) and manner stated. 29b. Signature and title of certifier		29c. License	number	2	9d. Date signe	d (Month 1	Day Year
1	F 3 F 8		I him his, mid		OCM			January		
								- arracit y	<u></u>	
			30. Name and address of person who completed cause of death (Item 23a) (T			0.				
	Sta	10	31 Date filed (Month Day Year) 324 egistrar's Signature		III Penn	Street	, Baltimo	ore, Ma	rylan (d 21201
	Registr		FEB 0 9 2005 Lineur &	Gran	de					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year hulak Steven Deott 952 eb 2005 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Glen Burrice Shelley KOAd If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Days Months Hours 1 X M 2 □ F Yrs. 214-72-0147 48 25 1956 PA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7815 Shelley Road 21060 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Tractor Trailer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Ρ. Chulak Anna Mae Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) (mother) Anna M. Chulak 1096 Woodlawn Avenue, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery 2005 Glen Burnie, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part 1. Enter the disease, or complications that shock, or heart failule. List only one cause of Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last nellitus (Abetes 23b. Did tobacco use contribute to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 1 10 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 1A Yes 2 □ No 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🗽 Pésidence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Box 68760, P.0. Division of Vital Records, After this certificate has the funeral director. I or Attending F after death. Director To the Hospital or within 24 hours aft To the Funerel Di

Physician

/Medical

Director

2

Completed

Be

ဂ္

Examiner

Funeral

Director

wohe

r than "neturel", or Items 23e or 28a-f eho the Medical Examiner must be notified at

nd Mental Hygiene. marked other than

permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Important: If item 27 Is marked when any Injury or other any Injury or ot Injury or other traumatic event,

Physician

/Medical Examiner

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

Physiclan/Medical ð Completed Be ဥ Certification:

Examiner

filled in by Medical

29a, Certifier

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Deputy

000605

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

695 VILLIAM

31. Date filed (Month, Day, Year)

32. Registrar's Signature

FEB 0 9 2005 Streve & Sports

State Registrar

			1 - State of Registrer	Maryland / Depa	artment of F <i>rtificate of l</i>	leaith and M <i>Death</i>	ental Hygie _{Reg.}		03854
,	Physici		1. Decedent's Name (First, Middle, Last) HELEN M. CLEME	N S			2. Date of Death Month FEBRUARY	Day 8, Year 200	
	/Medic Examin		4a. Facility Name (If not institution, give street and num. 4302 KOLB AVENUE	ber)		r Location of Death		4c. County of Dea	
	Funeral Director			. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye 4-1-1917		thplace (State or Foreign ountry) ryland
	yland		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
	the Mar 28a-f s	Director	MD BALTIMORE 10e. Street and Number		RASE	PEBURG	100	Citizen of Miles C	1 Tyes 2 No
	th with 23a or	al Dir	4302 KOLB AVENUE			21206	Tog.	Citizen of What C	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. If a Medical Exertinal mast be nelliked at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, Give Year or Date	No No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin? (Spe tn, Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)	14. Race - Ame Black, Whi	erican Indian, te, etc. WHTTE
21215-0036	in 72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of working	g 16b	. Kind of Business	/Industry
212	led with lygiene. har tha		Elementary/Secondary (0-12) College (1-4		OMEMAKER				OME
Maryland	uld be fi fental H rkad ot tic evar	To Be	17. Father's Name (First, Middle, Last) HENRY WESSEL			18. Mother's Name MANTEL	(First, Middle, Maid S:MI)		
lary	2 shou and N is mai	Γ.	19a. Informant's Name/Relationship (Type, Print)			and Number or Rural	Route Number, Ci	ty or Town, State,	Zip Code)
	1 and Health am 27 Athar tr		ELIZABETH HAAG/ DAUGHTE 20a. Method of Disposition		KOLB AVE		MA ZOCMI	RYLAND . Location - City or	21206
Baltimore,	tment of trant: If it it it or or or or or or or or or or or or or		1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from St. 4 ☐ Donation 5 ☐ Other (Specify)	PARKWOOD	CEMETERY	2–11-	-2005 B	altimore	, Maryland
Bai	Departiment Depart		21. Signature of Funeral Service Licensee	to 2	2. Name and Address 1211 CHES	ss of Facility CVA(SAC) AVENU	CH/ROSEDA E ROSEDA	LE FUNER LE, MARY	AL HOME LAND 21237
	7157		23a. Part1. Enter the disease, or complications that can shock, or heart failure. List only one cause on ear Immediate Cause (Final	used the death. Do not ent	\		respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	r as a consequence of):	thrue		-		In
	Examiner	<u>_</u>	Sequentially list conditions, if any, leading to immediate Due to (o	r as a consequence of):					415
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	CLOSONY	·~ 2				11/5
68760,	tificate be executed ig physician and as the burial-transit	al Exa	resulting in death) Last Due to (o	r as a consequence of):					
	tificate og phys as the	Medical	0						
P.O. Box	To the Hospital or Attanding Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physiclan/M	in the past 12 months?	nt at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
Ś	w requires that s been signed b should be deta	by	Part II. Dther significant conditions contributing to dea	th but not resulting in the u	nderlying cause give	en in Part I.	23e. Did tobacc		o the cause of death?
Division of Vital Record	The law recate has be page 2 sho	Completed					24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
Vita	lysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 Yes	actions a FR/Outration	t all DOA Othe	26. Place of Death		. Tou	
n of	ng Phy ter this neral d	H 1	27. Manner of Deat 28a. Date of	Datient 2 ER/Outpatien Injury 28b. Time of Injury	IL SEL DOA	4 🗀 Nuising Hom	e 5 X Residence 3d. Describe how in		cify)
Sion	ttandir death. tor: Af the fur	icatic	2 Accident investigation		M 1 []	Yes 2 □ No	26 1		
<u>></u>	tal or A	Certification:	determined 200.1 lace o	f Injury · At home, farm, str. g, etc. (Specify)	eet, factory, office	20	3f. Location (Street City or Town, St	and Number of Hi ate)	irai Houte Number,
	To tha Mospital or Attanding Phwithin 24 hours after death. To tha Funeral Diractor: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying Physician: To the base and manner.	is of examination and/or inv	n occurred at the tim vestigation, in my op	ne, date and place, ar pinion, death occurred	nd due to the cause d at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	To t To t	M	29b. Signature and title of certifier	0 000	29c. License			Date signed (Mont	h, Day, Year)
	Q	Ì	30. Name and address of person who completed cause	of thath (Item 23a) (Type,	Print) Alex	1 Feral	cy Mo	41103	11200
	Sta	te	31. Date filed (Month, Day, Year) 32 Reg	gistrar's Signature		11	150 17	~~ MO	121607
	Registr	ar	FEB 0 9 2005	we It Ap					

			1 - For State Registrer		artment of Health and rtificate of Death		ene 005	03855
I	Physic	ian	Decedent's Name (First, Middle, Last)		- 1	2. Date of Death Month		3. Time of Death
	/Medi Examir		William Angelo Cor	urpas, Sr.	4b. City, Town, or Location of Dea	February	7, 2005 4c. County of Death	4,10 P.M
	Exami		666 Geneva Drive		Westminster		Carrol1	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday				place (State or Foreign
	Director		215-28-2917 Usual Residence of Decedent	73 Yrs.	Monard Bays Hours IIII	Aug. 14,	1931	MD MD
	land ow		10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	Man a-f sh lifed	to	MD Carroll		Westminster			1 □ Yes 2√□ No
	th the	Director	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Cour	ntry?
	ath wi	ral	666 Geneva Drive		21157		USA	
	er der Itams	Funeral	Arme	Decedent Ever in U.S. 13. ed Forces?	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- irto Rican, etc.)	14. Race - Americ Black, White,	can Indian, etc.
50	irs aft	by F	If Ye	Yes 2 □ No s, Give or Dates: WW I I	1 ☐ Yes 2 🛣 No Specify:		Specify:	
5	d within 72 hours after death with the Maryland giene. In the "natural", or Itams 23a or 28a-1 show the Madical Examinatmust be notified at		15. Decedent's Education	16a. Dece	dent's Usual Occupation	16	Bb. Kind of Business/In	ite
V		Completed	(Specify only highest grade completed in the complete state of the		kind of work done during most of w DO NOT use retired)	orking		,
Maryland 21215-0036	e filed within al Hygiene. I other than ' vent, the Me	Con		1	0wner		Restauran	t
	l be filec ntal Hyg ed other event,	Be	17. Father's Name (First, Middle, Last)		18. Mother's Na	ame (First, Middle, Ma	aiden Sumame)	
Š	should be nd Menta marked matic ev	10	Angelo C. Courpas 19a. Informant's Name/Relationship (Type, Print	10b Mail		tha Anthis		
<u>8</u>	Ith an 12 s		Lois Constance Courpas	•	ng Address <i>(Street and Number or F</i> Geneva Drive, We:			Code)
ā,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic events.		20a. Method of Disposition	20b. Place of Dispo	osition (Name of		C. Location - City or To	own, State
ballinore,	Page not: If ry or		1 ₩ Burial 2 ☐ Cremation 3 ☐ Removal 1 3 4 ☐ Donation 5 ☐ Other (Specify)	TOTT STATE	matory or other place) ark Cemetery 2/	11/05 B	altimore, N	MD
<u>=</u>	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee		2. Name and Address of Facility		Reistersto	
<u>α</u>	89889	1	1 THYBELL		line Funeral Home	e Reiste	rstown, MD	
	/Medical bhysician and bhysician and the purial-transit sthe purial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	OII GACII IIIIG.	er the mode of dying, such as cardia		i,	Approximate Interval Between Onset and Death
	that the death certificated by the attending posterior is as	Physician/Medical	in the past 12 months?	regnant at time of death 5 [Inknown	Ectopic pregnancy Other (specify)	23a Did tohaa	23d. Date of delive	Day Year
	w requires been signi should be	Q		lone Knu			2 No 3 Proba	
Vital hecolds,	Aning Prinystolant: The law re The After this certificate has be funeral director, page 2 sh	e Completed	25. Was case referred to medical		00 200 - 4 20	24a. Was an autopsy performed 1 Yes 2 2	d2 prior to con death?	osy findings available inpletion of cause of 2 No
	this cer al direct	To B	examiner? 1 Yes 2 No Hospital:	☐ Inpatient 2 ☐ ER/Outpatien		ath (Check only one)	e 6 □Other (Specify	1
	our prospinal or Attaining Fripsican: within 24 hours after death. To tha Funaral Diractors After this certifics completely filled in by the funeral director, is	Certification:	1 Natural 5 Pending (1 2 Accident investigation	ate of Injury Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how		/
	within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide 6	lace of Injury - At home, farm, struilding, etc. (Specify)		City or Town, S		
	24 hours 24 hours a Funaral etely fillec	edical	Z Medical Examiner: On the	the best of my knowledge, death ne basis of examination and/or inv nanner stated.	occurred at the time, date and place restigation, in my opinion, death occu	e, and due to the caus urred at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
-	within 2 To tha	Mec	29b. Signature and title of certifier	4 , M.D.	29c. License number		Date signed (Month, E	Day, Year)
	Sta Registra		30. Name and address of person who completed of Noward Saintz Hill 31. Date filed (Month, Day, Year) 9 2005	cause of death (Item 23a) (Type, 555 Solution 2. Physistran's Signature	Canter Strag	t Luastn	uretu , t	1021157

Please Type or Print in Black Indelible Ink. Ensure All Coples Are Legible. and item 26 per phys 9840 2-9-05 vt. State of Maryland? Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** February 3, 2005 Margaret Clayton 8:24 P Ε. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Good Samaritan Hospital <u>N/A</u> 8. Date of Birth (Month, Day, Y)
June 24, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 💢 F Months Maryland 219-03-1456 85 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show other traumatic avant, the Madical Examiner must be notified at 1 X Yes 2 □ No Director Maryland N/A Baltimore City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with ō 6507 Harford Rd. 21214 U.S.A. Items 23a Completed by Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🔀
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 👿 No ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 Widowed 4 □ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 9 yr's 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Eberwein Marcie Hamilton Henry 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1314 Kitmore Road Baltimore, MD 21239 Ralph T. Clayton, Jr. - Son itam 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State ō <u>=</u> 1 XBurial 2 Cremation 3 Removal from State ō Department of Important: If eny injury or once. Gardens of Faith 2/7/05 Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 and 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASASTOLO Pnysician /Medical Due to () as a consequence of) **Examiner** Due to (or as a contribunce of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit oronary No sea se arter Due to (or as a consequence of). Box 68760. use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No ţ 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗽 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe roule 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Hospital: 1 ☐ Inpatient 2 ■ ER/Outpatient Other: 4 Nursing Home Sendence 6 Other (Specify) P 1 Yes 2 No 3□ DQA this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide tha Funaral Di within 24 hours a To the Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 YOTK Rd. TOWSON 1401,0

State Registrar strar's Signature

			1 - For State Registrar	State	of Marylar		artment of H rtificate of	lealth and N <i>Death</i>		giene Reg. No2 () (05	03857
I	Physici		1. Decedent's Name (First, Midde Loriene C. Castril						2. Date of De. Month February	ath	Year	3. Time of Death 6:30 P M
	/Medic Examin		4a. Facility Name (If not institution Good Samaritan Hos		umber)		4b. City, Town, o	r Location of Death		4c. County	of Death	
	Funeral Director		5. Social Security Number 236-36-9523	6. Sex 1 □ M 2√√F	7. Age (In yrs. 7 9	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da October		9. Birth Cou West	place (State or Foreign ntry) Virginia
	show	_	Usual Residence of Decedent 10a. State 10b. Count Maryland N/A	у	1	ty, Town or Lo	cation					10d. Inside City Limits
	n the Ma r 28e-f	irecto	Maryland N/A 10e. Street and Number		Do	ti tilibre	10f. Zip Code			10g. Citizen of V	Vhat Cou	1 XYes 2 No
	th wit	aiD	5803 Arizona Aven	ue			21206			USA		
936	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptygene. Important: If item 27 is marked other than "natural", or Itama 23a or 28e-f show any injury or other traumatic event, the Medical Evarth at must be notified at once.	by Funeral Directo	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	Armed F t Yes If Yes, G	2 (X) No live		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	14. Rac Blac Specify	k, White,	
Ò	2 ho	ted		ent's Education	13	16a. Dece	dent's Usual Occup	oation during most of work	kina	16b. Kind of Bi	usiness/ir	dustry
21215-0036	d within 7 giene. er than "r the Med	Completed by	Elementary/Secondary (0-12)	est grade completed College	(1-4or 5+)	life.	naker	d)	Ning :	Own Home	<u>. </u>	
	al Hy d oth	Be (17. Father's Name (First, Middle	e, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Surnam	10)	
yla	Ment Ment Marke Marke	L _o	Alfred Blevins					Oma Layme				
Maryland	12 sh h and 7 Is m traum	1 7	19a. Informant's Name/Relation Mary Ann Marshall/					and Number or Ru Venue Balt				Code)
Baltimore, I	permit. Pages 1 end 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, Ita Majical Examone.		20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other	a 3 □Removal from	- 01-1-	Place of Dispo	sition (Name of natory or other pla		Date	20c. Location - Baltimore	City or T	
Baltin	permit. F Departmo Importar any injur		21. Signature of Funeral Service			1ton 22	Name and Address Name and J. R BUS Harford	ess of Facility Puck Inc. I Road Ball	timore Mar		214	
	Pnysician /Medical Examiner	her	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	or complications that st only one cause on Due to Due to	caused the deal each line.	th. Do not ent	er the mode of dying	Aortic	or respiratory at	rest.		Approximate Interval Between Onset and Death
68760,	tificate be executed ig physician and as the burial-transit	edicai Examiner	resulting in death) Last	c	A FA o (or as a consec	enios quence of):	clerst	Ves.	se(1).	Iseas e		
O. Box	death cer e attendin id for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	utcome of pregn birth 2 Feta gnant at time of a nown	aldeath 3	Ectopic pregnanc Other (specify)	у		23d. Dai Mo	e of deliv	ery Day Year
rds, P	w requires that the sbeen signed by the should be detache	by	Part fl. Other significant condi	tions contributing to	death but not re	sulting in the u	nderlying cause gr	ven in Part I.	23e. Did to			he cause of death?
of Vital Records,	The law ate has by page 2 st	Completed								osy rmed?	Were auto prior to co death?	opsy findings available impletion of cause of
/ita	sician: Th certificate irector, pag	Be (25. Was case referred to medic examiner?					26. Place of Dea	th (Check only o	nne)		
of	S 50	10 10	1 Yes 2 Ato			ER/Outpatier	IL 3 DOA		ome 5 Resid	dence 6 Oth		(y)
OU (on (fter	tion	27. Manner of Death 1 ■ Natural 5 □ Pend	ding 28a. Date (Mo	nth, Day Year)	28b. Time of Injury	Wo	rk? Yes 2 No	200. Describe r	low injury occurr	G u	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	3 Suicide 6 Coul	d not be 28e. Place	ce of Injury - At h ding, etc. (Speci		reet, factory, office	7.40	28f. Location (S City or Tox	Street and Numb vn, State)	er or Run	al Route Number,
	ne Hospitu n 24 hours ne Funera pietely fille	edicai C		ring Physician: To the al Examiner: On the and ma								
)	To the within to the comp	M	29b. Signature and title of certification.	ier L	. /Sa	Ken	7) /) d	se number		29d. Date signed		
_	10		30. Name and address of personal description (1.	Baker	, Good	1 San	Print) Varitari	Hospita	11,Ba	Himor	- /	N
	Sta Regist		31. Date filed (Month, Day, Yea		egistrar's Sign	sture	note)					

	Į.	1 - For State Registrar 1. Decedent's Name (First, Middle, La	State of M		d / Depa	artment of rtificate o	Health a	and Me	ntal Hygi	ene 0	05	03858
Physicia /Medic	al	Edward J. Czarski 4a. Facility Name (If not institution, give	,		-	Ab City Town	, or Location of	F	. Date of Death Month	Day 05, 7	Year 2005	3. Time of Death 2:00 P M
Examin Funeral	er	Union Memorial Hospi 5. Social Security Number 6.3	tal Sex 7. Ag	e (In yrs. I	ast birthday)	Baltin If Under 1 Ye	ore		. Date of Birth	N,	A 9. Birth	place (State or Foreig
Director		Usual Residence of Decedent	1 XX M 2□F	94	Yrs.	Months Day	/s Hours	Min. Jl	Date of Birth (Month Day, UIY 27,	1910	Mary	71and
he Maryla 28a-f shov	ector	10a. State 10b. County Maryland Baltim	ore	10c. City	, Town or Lo	Baltimore						1 ☐ Yes 2 🔏 No
h with t	ai Dir	4300 Cardwell Avenue	Apt. 124			10f. Zip Code 2123			10	og. Citizen o USA	f What Cou	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. By Injury or other treumatic event, the Medical Evantrer must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Tyes 2V If Yes, Give Year or Dates:			Was Decedent of Yes, specify C	f Hispanic Orig uban, Mexican,	gin? (Specif , Puerto Ric	fy Yes or No- can, etc.)	14. Ra	ace - Americack, White,	etc.
ithin 72 ho le. han "natur Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	5+)	(Give	dent's Usual Occ kind of work dor DO NOT use ret	cupation ne during most ired)	of working	1	6b. Kind of		
id be filed w ental Hygier ked other th c event, Ins	To Be Cor	17. Father's Name (First, Middle, Last Unknown	Czarsk	i	Upho1	ster		r's Name (F	First, Middle, M	Furni 1 laiden Suma		
and 2 shoulalth and M	T	19a. Informant's Name/Relationship Jeanette Patricia Mil	Type, Print) 1s/Daughter		19b. Mailir 48	ng Address (Stre 18 Hamilt	et and Number On Avenue	or Rural R e Apt.	Route Number, 1D Balti	City or Town	n, State, Zip 2120	Code)
Pages 1 ament of He sent: If item ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 1 Donation 5 Other (Speci	fy)	Most	Holy R		2	Date 2/10/05	5 B	oc. Location	e Mary	
permit. Depart Import any inj		21. Signature of Funeral Service Lice	Helton		5.	Name and Add eonard J. 305 Harfoi	ress of Facility Ruck, Ir	nc. Baltim	nore Mary	land 2	21214	
Take fedures that the death certificate be executed as been signed by the attending physician and a should be detached for use as the burial-transit and the control of the	dical Examiner	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each ii	a conseque	Myoc uence of):	er the mode of d				st,		Approximate Interval Between Onset and Death
been signed by the attending of should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pregnar Other (specify)					ate of delive	ery Day Year
an signed by	þ	Part II. Other significant conditions	contributing to death b	ut not resu	ulting in the u	nderlying cause	given in Part I.			acco use con		he cause of death?
ate h page	Completed								24a. Was an autopsy perform	ed?	prior to co	psy findings available mpletion of cause of 2 No
certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ∰ No	Hospital:			-5-0.)thor		Check only one			
sath. or: After this he funeral d	ertification; To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation			28b. Time of Injury	28c. In	4 🗆 (Nult	280	5 Resider d. Describe hov			y)
within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	0	3 Suicide 6 Could not be determined	building, et						City or Town,	State)		I Route Number,
within 24 hours after To the Funeral Director Completely filled in	Aedical	one) 2 Medicel Exa	nysicien: To the best miner: On the basis o and manner sta	f examinat	wledge, death ion and/or inv	vestigation, in my	opinion, death	place, and h occurred	at the time, da	te and place	, and due to	the cause(s)
with To	Σ	29b. Signature and title of certifier		0 .			nse number			d. Date sign		Day, Year)
6		30. Name and address of person who		leath (Item	23a) (Type,	Print)	43894			2/06		dan to to
Sta Registra		Chiengenus Nuc 31. Date filed (Month, Day, Year) FFR 6 0 2		ar's Signat	TO!	· unive	rsing !	arku	vay B	altin	Love.	rangiand 21

State of Maryland / Department of Health and Mental Hygiene, State Registrar AMEND TTEM #6 PER FH G840 2 697 His cate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 1.30AM CALLAHANS 05 PROY FEB 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Lutherville Baltimore Co. Brightwood Center Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min 8. Date of Birth (Month, Day, Year) Jan. 23,1929 5. Social Security Number 9. Birthplace (State or Foreign Country) West Virginia 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1X M 2 ☐ F -92 76Director 254-32-6130 Usual Residence of Decedent filed within 72 hours efter deeth with the Marylend 10a. State 10c. City, Town or Location "natural", or Itams 23s or 28s-f show idical Examiner must be notified at 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Maryland Baltimore Lansdowne 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 United States 4230 Hollins Ferry Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3½ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. ther then " int, the Me Elementary/Secondary (0-12) College (1-4or 5+) 4 Years Fork Lift Operator Glass Co. Peges 1 and 2 should be flied vitnent of Health and Mentet Hygie tent: If item 27 is marked other to jury or other treumatic event, ib 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Laura Ogletree Callahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Wesley Woods Ct. Kingsville, Maryland 21087 Mrs. Cindy Cabral/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Dapartment of Important: If any Injury or once. Marriottsville, MD Crestlawn Cemetery 2/8/2005 □ Donation 5 □ Other (Specify) 21. Sign ture of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 29a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RONARI DISEASE years /Medical Due to (or as a consequence of): Examiner RIPHERAL VASCULAR DISTAGE Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner physicien and s the buriel-trensit The law requires that the deeth certificate be executed resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) cete hes been signed by the pege 2 should be deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 | Yes 2 | No of Vital Hospital or Attending Physician: funerel director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division 1 | Natural 5 Pending investigation 2 🗌 No within 24 hours efter daeth.

To the Funeral Director: A completely filled in by the fu 1 🗌 Yes 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier up te MD D0053150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40 POBOX 6303 2harun MACA COUPTA 31. Date filed (Month, Day, Year) State Seem It franke Registrar FEB 0 9 2005 DHMH 17 Rev 1/2001

Ira Cunningham 05-00975 amend/unpend item#1,23a,2/,28a-1, perMe, 684Z,4/II/05 III Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene RPD 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Ira James Cunningham, III Day **Physician** Year 11:05 P 6, February 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview N/A Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours tvETM 2□ F Director 218-02-5766 37 Yrs. April 15,1967 Maryland Usual Residence of Decedent Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits rel', or items 23s or 28s-f show Examiner must be notified at 1 Tyes 2 NNo Director Dundalk Maryland Baltimore the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Heatth and Mental Hyglene. ont: If item 27 is marked other than "naturel", or Items 23a or? 21222 7647 Charlesmont Road Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2K No Specify: Specify: White 3 Widowed 4 Divorced The Mudicul 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Home Elementary/Secondary (0-12) College (1-4or 5+) 9 Years Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ira James Cunningham, Jr. Mary Ellen Brown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brown Dale / Mother 6907 Dunmanway Apt. El Dundalk, Maryland 21222 Mary item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. Dublin Southern Cem. 2/10/2005 Dublin, Maryland ^ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Head Injuries /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (classes of injury) Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 3 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by sign be 1 Tes 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of deatb? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical Be 26. Place of Death C eck onl one examiner? Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 XYes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Special Certification: To 27. Manner of Death 28d. Describe how injury occurred UNK Pa. Date of Injury Find onth, Day Year) 28c. Injury at Work? Time of 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fi death. investigation 2/3/2005 2:52 p 1 ☐ Yes 2X No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Found at home 28f. Location (Street and Number of Rural Route Number, City or Town, State) 3936 Glenhurst Rd 4 Homicide Dundalk MD

Registrar

State

29a. Certifier

(Check only one)

29b. Signature and title of certif

31. Date filed (Month, Day, Year)

Name and address of person who completed caves

Medical

k mo

of death (Item 23a) (Type, Print)

32. Registrar's Signature

2005

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

O.C.M.E.

29c. License number

Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

February 7,2005

			1- For Amend Item 10c, e, i per in G840 2	artment of Health and M rtificate of Death	lental Hygi	ene g. N2. 005	03861					
	/ Dhysis	210	Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death					
	Physici /Medio		EDNA CRAWFORD		Z	Day Year 2005						
	Examir	ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea						
e: :		Ų.	JOHNS HORKING BAYNEW MEDICAL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore C: Hunder1Year Hunder24Hrs.	_		N/A					
	. Funeral Director		5. Social Security Number 220-36-2396 Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day,) May 12, 1	Year) 9. Bi 1929 Wes	nthplace (State or Foreign ountry) st Virginia					
	72 hours after death with the Maryland natural, or items 23s or 28s-f show dical Examiner must be notified at	tor	10a. State 10b. County 10c. City, Town or L Baltimore Engette				10d. Inside City Limits 1 Yes XXNo					
	s 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23s or 28a -f shov other treumetic event. If a Madical Examiner must be notilited as	Funeral Director	10e. Street and Number 8038 Stratman Road	10f. Zip Code 21222	100	g. Citizen of What C	ountry?					
	deat ems	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Am						
960	ours after dea ral', or Items Examiner m	by	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	nican, etc.)	Specify:	HITE					
21215-0036	within 72 hours ene. than "natural", re Medical Exa	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ing 16	Sb. Kind of Business	s/Industry					
	filed with Hygiene. other than	Co	9 Years	Assembler		Western I	Electric					
ng	be fill	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		,						
S	2 should be filed within and Mental Hygiene. Is marked other than eumetic event. It e M.	은	Donald Ervin		ta Calhou							
Maryland	nd 2 sho alth and 27 Is mu			ing Address <i>(Street</i> an <i>d Number or Rura</i> D Holly Grove Road								
	Health Health tem 27 other tr		20a. Method of Disposition 20b. Place of Dispo	osition (Name of		Oc. Location - City or						
JO.	Pages net of int; if it		La Burial 2 Defination 3 Definition State	matory or other place) wn Cemetery 2/7/20			e, Maryland					
Baltimore,	permit. Pages 1 ar Department of Hea Important: if item any injury or other once.	I I		2. Name and Address of Facility Duda-Ruck Funeral	Home of	Dundalk,	Inc.					
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en	7922 Wise Ave. Duter the mode of dying, such as cardiac of	indalk <u>. </u>	laryLand t,	21222 Approximate					
	Physician /Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. HYPERCAPBIA				Interval Between Onset and Death MINUTES.					
ľ	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury) Due to (or as a consequence of): Due to (or as a consequence of):	ICTIVE PULMONARY	DISEASE		MANY YEARS					
o,	ate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
68760,	ficate be physicial s the bu	edlcal	d									
O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	livery Day Year					
S,	res that igned b be deta		Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did toba	cco use contribute to	o the cause of death?					
ord	w requir been si should	ted	GASTROINTESTINAL BLEEDING		1 Tes	2 □ No 3 X P	robably 4 Unknown					
Il Records,		GASTROINTESTINAL BUSING 1 Yes 2 No 3 Probably 4 Unknown autopsy performed performed deaths 24a. Was an autopsy performed deaths 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 No 1 Yes 2 No 1 No 1 No 1 No 1 No 1 No 1 No 1 No										
Vital	lysician: This certificate director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	Check on one							
of	Phys this ral dil	lon: To	Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
Division		Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	M 1 Yes 2 No	28f. Location (Stree City or Town,	et and Number or R. State)	ural Route Number,					
Q	Hospital of the hours at Funerel D Funerel D tely filled in		29a. Certifier X Certifying Physicien: To the best of my knowledge, deat									
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	ledical	(Check only 2 Medical Examiner: On the basis of examination and/or in	vestigation, in my opinion, death occurre	ed at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)					
1	To Toon	M	29b. Signature and title of certifier New MAPHA 30. Name and address of person who completed cause of death (Item 23a) (Type. DR. VENKATEEN MURTHY, "144 EASTERN ATTEM ATTE	29c. License number	290	Date signed (Mont						
1	(V		30. Name and address of person who completed cause of death (Item 23a) (Type, DR . VENKATESH MURTH, 4949 EASTERN A	Print) EMERALTIMORE, MD	21224							
	Sta Registr	ite ar	31. Date filed (Month, Day, Year) 9 2005 32. Red Signature	P. Same								

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Certificate of Death
>	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 1- ZODM 4a. Feqility Name (If not institution, give street and number) 4b. City, Town, or Location of Death TIZA BETH NUSTRA CENTER TOWN.
	Funeral Director		5. Social Security Number 027-05-8661 6. Sex 1 Months Days Hours Min. 1 Months Days Hours Min. 4 PRIL 1, 1914 MA
	he Maryland 28e-f show	ector	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD HOWARD ELLICOTT CITY 1 □ Yes 2√√√√√√√
	h with t	ai Dir	106. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 USA
036	72 hours after death with the Maryland naturel; or Items 23a or 28e-f show lical Examinational barnoillied at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 No If Yes, 2 No If Yes, 2 No Specify: 1 Yes 2 No Specify:
21215-0036	within ene. then "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WEAVER 16b. Kind of Business/Industry TEXTILE MILLS
	d be filed intal Hygi ed other c event, I	Be	17. Father's Name (First, Middle, Last) PETER CANAS 18. Mother's Name (First, Middle, Maiden Sumame) EVELINE BOURQUE
, Maryland	1 and 2 should be 1 Health and Mental I tem 27 is marked o	To	19a. Informant's Name/Relationship (Type, Print) SUSAN A. SMITH daughter 9388 FURROW AVE. ELLICOTT CITY, MD. 2104:
altimore,	0 0		20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State (A Contains 5 Other (Specify) 20b. Place of Disposition (Name of City or Town, State WESTLAWN CEMETERY) 20c. Location - City or Town, State FEB . 10, 2005 LOWELL, MA
Balt	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY W. JENKINS & SONS CO 16924 YORK RD. MONKTON, MD. 21111
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of):
x 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Examiner	resulting in death) Last C. Due to (or as a consequence of): d
.O. Box	that the death ed by the atter detached for u	hysiciar	23b. Was decedent pregnant in the past 12 months? 1
ords, P.	w requires that been signed I should be det	by	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Minknown
of Vital Records,		Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
f Vit	ys dir	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Ot
ion o	nding Ph ath. r: After th e funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No
Division	tel or Attendesti s after desti el Director: ed in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
)		2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Feb may 7, 7005
1	5(1		30. Nahel and address of person who complet Lause of death (Item 23a) (Types Print) Wing V, 3350 Benson Avenue; Baltimore Maryland 21227
	Sta Registi		31. Date filed (Moghth, Day Year) 32. Regignary's Signature FEB 0 9 2005

			For State Registrar	State of Maryland /		irtment of H tificate of L		Mental Hy	giene Reg. No. 2	005	03863
			1. Decedent's Name (First, Middle, Las	st)				2. Date of De	eath Day	Year	3. Time of Death
	Physici /Medio		George Clay					02	06	2005	11:55 A ^M
h	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or		th		unty of Death	
			Joseph Richey Ho 5. Social Security Number 6. S	•	nirthday)	Baltimo	re If Under 24 Hrs	8. Date of Bi	rth	N/A	lece (State or Foreign
	Funeral Director			M 2□F 49	Yrs.	Months Days	Hours Min		ay, Yeer)	Cour	yland
	D		Usual Residence of Decedent			1					
	urylan show		10a. State 10b. County	10c. City, To	wn or Lo	cation				1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	8a-f	Sc to	Md Baltimor	te Essex	ζ	T					
	with th		10e. Street and Number	0: 1		10f. Zip Code			_	of What Cour	stry?
	eath	era	1415 Winter Park	12. Was Decedent Ever in U.S.	13. V	21221 Vas Decedent of Hi	spanic Origin?	Specify Yes or N	U.S	· A. · Race - Americ	an Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if Item 27 is marked other then *natural', or Itams 23a or 28a-f ehow important; if Item 27 is marked other then *natural', or Itams 23a or 28a-f ehow any Injury or other traumatic event, Ira Madical Examilian Installe multified at ORGE.	by Funeral Director	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1:	Yes, specify Cuba I□Yes 2 / No	n, Mexican, Pue Specify:	rto Rican, etc.)		Black, White, ecify: Blac	
Š	2 hou	Completed by	15. Decedent's Ed		a. Deced	lent's Usual Occupa	ation	attina	16b. Kind	of Business/In-	dustry
215	thin 7	nple	(Specify only highest gra	College (1-4or 5+)	life. L	kind of work done o OO NOT use retired)	Jikiliy			
Maryland 21215-0036	ed wi	S	12		N/A		40 14-4-4-14	(Class & Side)	N/A		
and	be fil d oth	Be	17. Father's Name (First, Middle, Last) George Clay Sr				Mary W	ine ton	e, Maiden Sui	mame)	
2	hould d Mer mark matic	T ₀	19a. Informant's Name/Relationship	Type Print)	9b Mailin	g Address (Street			per City or To	wn State Zin	Code)
<u>≅</u>	id 2 s ith an 27 is i					Winter P					
ē,	s 1 ar f Hea ftem other		Mary Clay 20a. Method of Disposition	20b. Place	of Dispo	sition (Name of natory or other place		Date	20c. Locati	ion - City or To	own, State
e E	Page: ent of nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 3 ☐ Other (Specified)	Hemoval from State				08-2005	Balti	more,Ma	aryland
Baltimore,	permit. Departm Importa any Inju		21. Signature of Funeral Service Licer	nsee		Name and Addres					, P.A. vland 21229
			23a. Part1. Enter the disease, or com	plications that caused the death. D	o not ent	er the mode of dyin	g, such as cardia	ac or respiratory	arrest,		Approximate Interval Between
	Physician		shock, or heart failure. List only	a. A = 72 c n e C	F	2mm11128	Dec	1018-0-	Dine	26.50	Onset and Death 25 years
	/Medical		disease or condition resulting in death)	a. Due to (or as a consequence	e of):		VEF	(100)	1, 3-	3 (20/60
	Examiner		Sequentially list conditions,	b							
	D is	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequenc	e ot).						
V	and I-tran	хаш	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequent	e of):					-	
8760,	icate be executed physician and s the burial-transit			4	,-						
687	ficate physics the	edical		_ d							
Вох	death certifica attending ph d for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy		Ectopic pregnancy			23d	. Date of delive	ery Day Year
P.0.	that the de sed by the a detached t	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5	Other (specify)					
-	w requires that to be the second by should be detailed by	b	Part II. Other significant conditions of	contributing to death but not resulting		nderlying cause give	en in Part I.		tobacco use		ne cause of death?
ord	requi	eted	13743012	1//300 4	es.						
Division of Vital Records	The la ate has page 2	Completed				<u> </u>		24a. Wa: auto perf 1 ☐ Yes	s an 2 opsy omed? 2 No	4b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of
/ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?					eath (Check only			
of/	S .9	2	1 □ Yes 2 No			t 3 DOA Oth	4 Nursing		**		viltospice
n C	Jing F	lon	27. Manner of Death 1 Natural 5 □ Pending	(Month, Day Year)	Injury	Worl	yat k? Yes 2 ∐ No	28d. Describe	now injury or	ccurred	
isi	death death ctor: y the	ical	2 Accident investigation 3 Suicide 6 Could not b	e and Place of Injury At home	farm, str			28f. Location	(Street and N	lumber or Rura	al Route Number,
Ο̈́	s after s after al Dire	Certification:	4 Homicide determined	building, etc. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To	own, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		nysicien: To the best of my knowled miner: On the basis of examination and manner stated.							
	To th To th comp	Me	29b. Signature and title of certifier	1		29c. Licens				igned (Month,	
			> Thed C.	Steanfr		D	1438	3	2	16/3	2005
	1		30. Name and address of person who		a) (Type,	Print)	1195	ep h	RICL	4 1 H	2005 25pscl
		ate	31. Date filed (Month, Day, Year)	33 Registrar's Signature	1		, - 0.			,	
	Regist	rar	1 2 0 21	Commence of	45	3432					

		-	Tiogram at	tment of Health and Mei ificate of Death	ntal Hygien	-000 000H
	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last) Lucia DiAntonis 4a. Facility Name (If not institution, give street and number)		600 naci	Year 3. Time of Death
	Examin	ŭ.	5. Social Security Number 6. Sex $ 1 - 05 - 2742 $ 1 $ 1 - 1 - 05 - 2742 $ 1 $ 1 - 1 - 05 - 2742 $ 1 $ 1 - 1 - 05 - 2742 $ 1 $ 1 - 1 - 05 - 05 - 05 $ 97 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min.	Date of Birth (Month, Day, Year	n/a 9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		-28-190	
	death with the Maryland ms 23e or 28a-f show rnust be natified at	'n	10a. State 10b. County 10c. City, Town or Loc 10c MD Baltimore Dundalk	ation		10d. Inside City Limits 1 ☐ Yes 2X No
	ith the Marylar or 28a-f show	irect	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
()	23a o	raiD	1905 Tolson Avenue	21222		USA
100 J	after or ite	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	as Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ric □ Yes 2[XNo <i>Specify:</i>	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
5-0036	72 hours "naturel",	ted	15. Decedent's Education 16a, Decede	ent's Usual Occupation	16b.	Kind of Business/Industry
121	i within iene. r than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ind of work done during most of working O NOT use retired) nemaker		own home
\bigcirc	e filed v Il Hygie other	Be Co	6th ROI 17. Father's Name (First, Middle, Last)	18. Mother's Name (F		
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	s 1 and 2 should be filed within the that and mhantal Hogiene. Items 7 is marked other than other traumatic event, Ins.M.	To B	Vincenzo Polci	Theresa	unk	
J 6	2 sho and I			Address (Street and Number or Rural R		
	s 1 and 2 item 27 other tra		20a. Method of Disposition 20b. Place of Dispos	Gough St. Balti		ID 21224 Location - City or Town, State
- Luc	Pages nent of ont: If it		1 □ Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 🛎 Other (Specify) entomb	e Park 2/10/	2005 Ba	ltimore, Maryland
			21. Signature of Funeral Service Licensee 22.	Name and Address of Facility Jose 53 S. Conkling S	eph N. Z St.Balti	Zannino Jr. FH More,MD 21224
	•		23a Vart 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac or r	espiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical	9	Inmediate Cause (Final disease or condition resulting in death)	19		
	Examiner		Due to (or as a consequence of):			
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
V	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events c			
760	e be e /sician e buria		d			
a	ng phy as th	Medi	IF FEMALE:			
3		Physician/Medical	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome or pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	uires that signed b	by	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death? 2 \(\sum \) No \(3 \sum \) Probably \(4 \sum \) Unknown
Sprood Icily so	le law requ	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
5	en: The	0	25. Was case referred to medical	26. Place of Death (1 Yes 2 1	No 1 Yes 2 No
	hystoli his cer I direct	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Dther		6 ☐Other (Specify)
9	ling PI		27. Manner of Death 1 → Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	d. Describe how in	jury occurred
	or Attend frer death director:	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)		f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	Hospitel 24 hours e Funerel (etely filled	edicai Ce	29a. Certifler (Check only one) Medical Examiner: On the best of my knowledge, death control of examination and/or inv and manner stated.			
	To the within To the compl	Me	29b. Signature and title of certifier Thomas MP	29c. License number	29d. 0	Date signed (Month, Day, Year)
	K		30. Name and a riess of person who completed cause of death (Item 23a) (Type, I	Print) Clo Ma	wand	General Hossita
	St Regist	ate rar	31. Date filed (Month, Day, Year) 2005 32. Jegistrar's Signature		- Juni U	

	•	State of Ma State Unpend Item 23a,27,28a	aryland/Dep - f per me e	artment of Health and I G840 .2-16-05, tas rtificate of Death	Mental Hygid	ne 005	03865
		Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
Physici		JOHN	Dive	L Jr.	FEBRUAR	$\overset{\text{Day}}{Y}$ 7, $2\overset{\text{Year}}{005}$	10:35 P ^M
/Medio Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	10.35 1
Lxaiiii	CI	420 S. MACON STREET		BALTIMORE CITY			
Funeral Director		5. Social Security Number 6. Sex 1.23 0 - 64 - 5 1 4 3 125 M 2 □ F	6 (In yrs. last birthday, 50 Yrs.		8. Date of Birth (Month, Day, Y		lace (State or Foreign try) 2 Y IAND
and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		1	Od. Inside City Limits
f sho	0	PA FULTON	MAREN	PDSBURG			1 ☐ Yes 2 ☑ No
28e-	ect	10e. Street and Number	MIKIO	10f. Zip Code	100	J. Citizen of What Coun	atry?
FIZ 15-UUSO I within 72 hours after death with the Maryland liene. liene. r than "netural", or items 23e or 28e-f show the Madical Examiner must be notified at the Madical Examiner.	Funeral Director	219 MALLARD RUN	LANC	17267		U.S.A.	,
Seath ns 2:	era	11 Marital Status 12. Was Decedent I		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Americ	an Indian,
riter of	Ē	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ N	No 1972		o Rican, etc.)	Black, White,	etc.
hours after tural; or ite	þ	3Å Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Specify:		Specify: W	Lite
72 hours "netural",	ompleted	15. Decedent's Education	16a, Dece	edent's Usual Occupation	fring 16	b. Kind of Business/Inc	dustry
Pin 7	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	ife.	e kind of work done during most of wor DO NOT use retired)	Kirig		11 /
M wild will be the common of t	Con	11+4		ASSEMBLER_	(SENERAL	MoteRS
al Hy t oth	Be (17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma	niden Surname)	
Ment b	2	John Dire	CL DA	2. HAR	eriet	1	unn
re, Mary s 1 and 2 should Heelth and M tem 27 Is mar		19a. Informant's Name/Relationship (Type, Print)		ing Address (Street and Number or Ru		- 11	Code)
and and a sellth n 27		JOHN W. DIreL III -	50N 713	5. EAST A	venue	5A/te/	1) 21224
		20a. Method of Disposition 1 ■ Surial 2 □ Cremation 3 □ Removal from State	20b. Place of Disp	osition (Name of ematory or other place)	Date 20	c. Location - City or To	own, State
nit. Pages artment of ortant: If It Injury or c		*4 □Donation 5 □ Other (Specify)	(Rest 1	my Ceneter Feb	11, 2005 K	AnnotesVILLE	2 MD.
mit. rmit. poartr poorts y Inju		21. Signature of Funeral Service Licensee	2	2. Name an Address of Facility Chances 5 Zan	inno Lie	CENSED HO	opticina
n 88558	1. 114	El Launen		P.O. Box 23942	Baltin	ere MD &	2/203
		23a. Part1. Enter the diseate, or complications that caused shock, or heart failure. Li conty one cause on each lin	the death. Do not er				Approximate Interval Between
Fnysician				tion(methadone And			Onset and Death
/Medical		resulting in death)	a consequence of):	, , , , , , , , , , , , , , , , , , ,			
Examiner		Sequentially list conditions b.					
	je		a consequence of):			i i	
cuted nd ransi		Cause (Disease or injury					
	an	that initiated events c.					i i
e exe	Examiner	that initiated events resulting in death) Last c. Due to (or as	a consequence of):				à
3 / 6U, ate be executed nysician and he burial-transit	cal	that initiated events resulting in death) Last c. Due to (or as	a consequence of):				,
× -	cal	Due to (or as	a consequence of):				
× -	cal	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	of pregnancy	— □Ectopic pregnancy		23d. Date of delive	
. BOX 68/ death certificate e attending phys of for use as the	cal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	of pregnancy 2	□Ectopic pregnancy		23d. Date of delive Month	ery Day Year
. BOX 68/ death certificate e attending phys of for use as the	cal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	of pregnancy 2 Fetal death 3 t time of death 5	Other (specify)		Month	Day Year
. BOX 68/ death certificate e attending phys of for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	of pregnancy 2 Fetal death 3 t time of death 5	Other (specify)		Month	Day Year
. BOX 68/ death certificate e attending phys of for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	of pregnancy 2 Fetal death 3 t time of death 5	Other (specify)		Month	Day Year
av requires that the death certificate is been signed by the attending physical should be detached for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	of pregnancy 2 Fetal death 3 t time of death 5	Other (specify)	1 ☐ Yes 24a. Was an	Month cco use contribute to the 2 No 3 Prob	Day Year
I Kecords, P.O. Box 68/ The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	of pregnancy 2 Fetal death 3 t time of death 5	Other (specify)	1 ☐ Yes	Month cco use contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to contribute to contribute the contribute to the contribu	Day Year ne cause of death? hably 4 Unknown psy findings available
I Kecords, P.O. Box 68/ The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the	e Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death b	of pregnancy 2 Fetal death 3 t time of death 5	Other (specify) underlying cause given in Part I. 26. Place of Dec	1 ☐ Yes 24a. Was an autopsy	Month cco use contribute to the contribute to the contribute autoprior to contribute to the contribute to the contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to the contribute to contr	Day Year ne cause of death? tably 4 Unknown psy findings available mpletion of cause of
I Kecords, P.O. Box 68/ The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	of pregnancy 2 Fetal death 3 t time of death 5	underlying cause given in Part I. 26. Place of Dec	1 Yes 24a. Was an autopsy perform 1 Yes 2 [ath (Check only one,	Month cco use contribute to the contribute to the contribute autoprior to contribute to the contribute to the contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to the contribute to contr	Day Year ne cause of death? nably 4 Unknown psy findings available mpletion of cause of 2 No
I Kecords, P.O. Box 68/ The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 25. Was case referred to medical examiner? 1 Yes 2 No 9 Hospital: 1 Inpatie	of pregnancy 2 Fetal death 3 t time of death 5 but not resulting in the	Underlying cause given in Part I. 26. Place of Dean and 3 DOA Other: 4 Nursing H	1 Yes 24a. Was an autopsy perform 1 Yes 2 [ath (Check only one,	Month cco use contribute to the contribute to the contribute to the contribute and? 24b. Were auto prior to contribute and? No 12 Yes ce 6 10 Other (Specific	Day Year ne cause of death? nably 4 Unknown psy findings available mpletion of cause of 2 No
I Kecords, P.O. Box 68/ The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death be carminer? 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatie Impati	of pregnancy 2 Fetal death 3 t time of death 5 but not resulting in the	Underlying cause given in Part I. 26. Place of Dean and 3 DOA Cther: 4 Nursing For 28c. Injury at	24a. Was an autopsy perform 12 Yes 2 Sath (Check only one, lome 5 Resident 28d. Describe how	Month cco use contribute to the contribute to c	Day Year ne cause of death? habiy 4 Unknown psy findings available mpletion of cause of 2 No y) Scene unk
I Kecords, P.O. Box 68/ The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown 25. Was case referred to medical examiner? 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 5 28e. Place of Injuriding, etc. 28e. Place of Injuriding, etc	of pregnancy 2 Fetal death 3 t time of death 5 but not resulting in the ent 2 ER/Outpatie ury y Year) 28b. Time Forthid	Underlying cause given in Part I. 26. Place of December 3 DOA Other: 4 Nursing For Work? 1 Yes 2 X No	24a. Was an autopsy performed to the control of the	Month cco use contribute to the contribute to t	Day Year ne cause of death? nably 4 Unknown psy findings available mpletion of cause of 2 No y) Scene unk
I Kecords, P.O. Box 68/ The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	of pregnancy 2 Fetal death 3 t time of death 5 interest a constitution of the second	underlying cause given in Part I. 26. Place of Decent 3 DOA Other: 4 Nursing For Versey 1 Yes 2 No treet, factory, office	24a. Was an autopsy performed by so 2 I ath (Check only one) 28d. Describe how 28d. Location (Streetly or Town, Baltimore)	Month cco use contribute to the contribute to the contribute to the prior to contribute to the contribute to contribute t	Day Year The cause of death? The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death.
I Kecords, P.O. Box 68/ The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	of pregnancy 2 Fetal death 3 t time of death 5 but not resulting in the sent 2 ER/Outpatie gry Year) 28b. Time Found 10:30 jury - At home, farm, s.c. (Specify)	underlying cause given in Part I. 26. Place of Decent 3 DOA Other: 4 Nursing For Work? PM 28c. Injury at Work? 1 Yes 2 X No treet, factory, office	24a. Was an autopsy perform 12 Yes 2 Sath (Check only one, tome 5 Resident 28d. Describe how 28f. Location (Street, City or Town, Baltimore)	Month cco use contribute to the contribute to t	Day Year The cause of death? The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death.
I Kecords, P.O. Box 68/ The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the	edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	of pregnancy 2 Fetal death 3 t time of death 5 but not resulting in the sent 2 ER/Outpatie gry Year) 28b. Time Found 10:30 jury - At home, farm, s.c. (Specify)	underlying cause given in Part I. 26. Place of Dea ant 3 DOA Other: 4 Nursing F of 28c. Injury at Work? 1 Yes 2 No treet, factory, office	24a. Was an autopsy performs 24 a. Was an autopsy performs 28 c. Check only one, lome 5 — Resident 28 d. Describe how 28 f. Location (Streetly or Town, Baltimore), and due to the caurred at the time, date	Month cco use contribute to the contribute to t	Day Year The cause of death? The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death.
of VItal Records, P.O. Box 68/ Physician: The law requires that the death certificate r this certificate has been signed by the attending physical director, page 2 should be detached for use as the	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	of pregnancy 2 Fetal death 3 t time of death 5 out not resulting in the out not resulting in the part 2 ER/Outpatie part 2 Bb. Time Totnd 10:30 jury - At home, farm, s ic. (Specify) of my knowledge, deaf examination and/or lated.	underlying cause given in Part I. 26. Place of Dea 27. Place of Dea 28. Injury at Work? 1 Yes 2 No treet, factory, office 29c. License number	24a. Was an autopsy performs 12 Yes 2[ath (Check only one, lome 5 Residen 28d. Describe how 28f. Location (Street, or Town, Baltimore, and due to the caurred at the time, dat	Month cco use contribute to the contribute to t	Day Year The cause of death? The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death.
I Kecords, P.O. Box 68/ The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the	edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	of pregnancy 2 Fetal death 3 t time of death 5 out not resulting in the out not resulting in the part 2 ER/Outpatie part 2 Bb. Time Totnd 10:30 jury - At home, farm, s ic. (Specify) of my knowledge, deaf examination and/or lated.	underlying cause given in Part I. 26. Place of Dea ant 3 DOA Other: 4 Nursing F of 28c. Injury at Work? 1 Yes 2 No treet, factory, office	24a. Was an autopsy performs 12 Yes 2[ath (Check only one, lome 5 Residen 28d. Describe how 28f. Location (Street, or Town, Baltimore, and due to the caurred at the time, dat	Month cco use contribute to the contribute to t	Day Year The cause of death? The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death.
DIVISION Of VITAI RECORDS, P.O. BOX 68/0 within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	of pregnancy 2 Fetal death 3 t time of death 5 but not resulting in the sent 2 ER/Outpatie gry 28b. Time Found 10:30 jury - At home, farm, s.c. (Specify) of my knowledge, deaf examination and/or lated.	underlying cause given in Part I. 26. Place of Decent 3 DOA Other: 4 Nursing Fof 28c. Injury at Work? 1 Yes 2 No No Itreet, factory, office 29c. License number OCME 2, Print)	24a. Was an autopsy performs 12 Yes 2 Sath (Check only one, lome 5 Resident 28d. Describe how 28f. Location (Streetly or Town, Baltimore), and due to the caurred at the time, dat	Month cco use contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to contribute	Day Year The cause of death? The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death.
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicians by the funeral director, page 2 should be detached for use as the	edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown 25. Was case referred to medical examiner? 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28a. Place of Injuilding, etc. 27. Medical Examiner: On the basis of and manner st. 29b. Signature and title of certifier 24 30. Name and address of person who completed cause of 24 31 31 31 31 32 32 32 32	of pregnancy 2 Fetal death 3 t time of death 5 but not resulting in the sent 2 ER/Outpatie gry 28b. Time Found 10:30 jury - At home, farm, s.c. (Specify) of my knowledge, deaf examination and/or lated.	underlying cause given in Part I. 26. Place of Decent 3 DOA Other: 4 Nursing Fof 28c. Injury at Work? 1 Yes 2 No No treet, factory, office ath occurred at the time, date and place nivestigation, in my opinion, death occurred at the course of the cours	24a. Was an autopsy performs 12 Yes 2 Sath (Check only one, lome 5 Resident 28d. Describe how 28f. Location (Streetly or Town, Baltimore), and due to the caurred at the time, dat	Month cco use contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to contribute	Day Year The cause of death? The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death. The cause of death.

DHMH 17 Rev 1/2001

ORIGINAL

	1 - For State Registrar	-	epartment of Health and I Certificate of Death	Mental Hygiene Reg. No.	2005 03866
	Decedent's Name (First, Middle, Last)		1	2. Date of Death Month Day	3. Time of Death
Physician /Medical	Vincent	H Dai	lex	FEBRYART,	6 ,2005 12:30 PM
Examiner	4a. Facility Name (If not institution, give si		46. City, Town, or Location of Deat		County of Death NIA
	SAINI AGNES +	EALH CARE 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs	8. Date of Birth	9. Birthplace (State or Foreign
Funeral Director		M 20 F 86 Y	Months Days Hours Min.	Jun 15 19	18 Country)
Pu »	Usual Residence of Decedent 10a. State 10b. County № 🗚	10c. City, Town	or Location		10d. Inside City Limits
anyla ed el	No. county is in	B-	Himore		1 ∰Yes 2 □ No
with the Mar n or 28s-1 ol be notified Director	10e. Street and Number	1.00	10f. Zip Code	10g. Citi	zen of What Country?
death with the Maryland ma 23a or 28a-f show rount to notified at	31 Blooming	rdale Aux	2 31228		USA
Site death virteme 23e	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer		 Race - American Indian, Black, White, etc.
036 ours after of all, or flor Expudited by Fun	1 Never Married 2 Marned 3 Widowed 4 Worvorced	1 Nes 2 No Year of Dates:	1 ☐ Yes 2 TNo Specify:	~	Specify: White
5-003	15. Decedent's Educ	ation 16a. [Decedent's Usual Occupation		nd of Business/Industry
21215-00 ed within 72 houygienen 'natura nat	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	Give kind of work done during most of wo life. DO NOT use retired)		$C \setminus a$
ed will ygien ygien yt, the	The second secon		Salesmo	me (First, Middle, Maiden	Sumamel
and and other sevents	17. Father's Name (First, Middle, Last)	Dailer	M CIN	Ci Anne	Thompson
re, Maryland 21215-0036 I and 2 should be filed within 72 hours after Heelth and Mental Hygiene. Heelth and Mental Hygiene. Heelth and Mental Hygiene. To Be Completed by Fu	19a. Informant's Nama/Relationship (Type		Mailing Address (Street and Number or R	ugai Route Number, City o	
e, Ma 1 and 2 a Heelth at em 27 is	Victoria Do	11/4/ 31	Bluminopale A	re Balto	MD 31328
Baltimore, Maryland 21215-0036 sernit. Pages 1 and 2 should be filed within 72 hours all Department of Heelth and Mental Hygientent of Heelth and Mental Hygientent of International Hygient than "natural", or my injury or other traumatic event, the Medical Exerci- Dince. To Be Completed by F	20a. Method of Disposition 1 Darial 2 Peremation 3 DR	cometen	Disposition (Name of crematory or other place)	Date 20c. Lo	cation - City or Town, State
timent rtment rtant:	' 4 □ Donation 5 □ Other (Specify)	NIE	22. Name and Address of Pacility	-11-05 15	9110/110
Baltimore, Mispermit. Pages 1 and 2 Department of Heelth a Important: if item 27 item	21. Signature of Lineral Pervica License	J. Vhach	TAM 1232 Mid	1.16/lar Dr.	JOSCIA PAIRUZY
TALL CT	23a. Part1 Enter the disease, or complia	eations that caused the death. Do no	ot enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between
Physician	Immediate Cause (Final disease or condition		CEMIA		Onset and Death Q WEEKS
/Medical Examiner	resulting in death)	D 4- (= 2 WEEKS
\$2.	Sequentially list conditions,	Due to (or as a consequence o		311115	
executed in and inial-transit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		•		
exect an an an an an an an an an an an an an	resulting in death) Last	Due to (or as a consequence o	f):		
18760, Cate be executed physician and she burial-transit she burial-transit cidical Examin					
x 68 antifica ding plans	IF FEMALE:	Bc. If yes, outcome of pregnancy			23d. Date of delivery
Cords, P.O. Box 6 wrequires that the death certiful been signed by the attendings should be detached for use as greed by Physician/Meleted by Physician/Mele	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
tthe d	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			
S, P Ss tha	Part II. Dther significant conditions con				use contribute to the cause of death?
Cord w require s been si should I	CORONATET	ARTERY			□ No 3 □ Probably 4 ☑ Unknown
0 e 8 c 0	AORIC	CTEHOS!	<u>S</u>	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital F vicion: The continuate rector, page			26 Place of Do	1 ☐ Yes 2 ☑No	1 ☐ Yes 25€ No
of Vita Of Vita Physician: this certific	25. Was case referred to medical examiner? 1 □ Yes 2★ No	ospital: 1 ★ npatient 2 ☐ ER/Out	Other	Home 5 Residence	6 ☐Other (Specify)
on of of of of of of of of of of of of of	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. T	ijury Work?	28d. Describe how inju-	y occurred
Vision Vision Attending r death. ector: After by the fune	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No	28t Location (Street as	d Number or Rural Route Number,
Division of Division of State death. Bal Director: After the ded in by the funera certification:	4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	City or Town, State	e)
		ician: To the best of my knowledge	death occurred at the time, date and place	ce, and due to the cause(s	and manner as stated.
o the Hosp thin 24 hou o the Fune impletely fill	(Check only 2 Medical Examinate)	ner: On the basis of examination and manner stated.	1/or investigation, in my opinion, death occ	curred at the time, date and	d place, and due to the cause(s)
To t within To t com		Atta.	29c. License number		te signed (Month, Day, Year)
	beflect DMV		Type Print)	1+BY	CHAIC 1, 6, 2005
3	30. Name and address of person who co		41NT AGNES HEA	CHICANO,	BAGIMONE, MARTUND
State	at Date filed (Menth Day Voor)	324Registrar's Signature	diaste)		

	•	For State Registrar	State of Marylan		artment of rtificate o		Mental Hy	giene Reg. No.	2000	03867
0		1. Decedent's Name (First, Middle, Last)					2. Date of De		. Your	3. Time of Death
Physicia /Medic		ANGELA M	ARIE EDWARDS				Month Februar	Day V 9	7 Year 2005	5:00 a M
Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town	, or Location of Dea	th	_	County of Death	
		JOSEPH RICHIE HOS	PICE		BALT	IMORE			N/A	
Funeral		5. Social Security Number 6. Sec	7. Age (In yrs. i		If Under 1 Ye Months Day			th v. Year)	9. Birth	place (State or Foreign intry)
Director		135-52-8999]M 2[X]F 4	7 Yrs.		, , , , , , , , , , , , , , , , , , , ,	AUG 27	195	7 MAI	RYLAND
D .	ŀ	Usual Residence of Decedent 10a, State 10b, County	100 Cin	y, Town or L	ocation					10d. Inside City Limits
aryla shor	<u>~</u>	Tou. State	100. 010							1 ☐ Yes 2 No
he M	Director	MARYLAND BALTIM	ORE	ESS						
with t		10e. Street and Number			10f. Zip Code			-	izen of What Cou	intry?
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Modical Examinating must be rotified at	Funerai	924 ASHBRIDGE DR	APT 13J 12. Was Decedent Ever in U.	C 12	212		Specify Ves or N	U.S	. A . 14. Race - Amer	ican Indian
iter d	Š	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔀 No	3. 10.	If Yes, specify C	of Hispanic Origin? (uban, Mexican, Pue	nto Rican, etc.)		Black, White	
I', or	by F	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X N	No Specify:			Specify: BLA	CK
"natural",	ed	15. Decedent's Edu	cation	16a. Dece	dent's Usual Oc	cupation		16b. Ki	ind of Business/li	
	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	kind of work do DO NOT use ret	ne during most of wo iired)	orking			
the second	E o	12th grade	College (1-401 5+)	BUS	INESS EX	ECUTIVE			INSURA	NCE
ital Hygiene. Ind other then "natuevent, the Medical	Be C	17. Father's Name (First, Middle, Last)					me (First, Middle	, Maiden	Sumame)	
ked ice	To B	EARL MURRAY				MARTH	A STATON	1		
and Mental Hygists marked other aumatic event, I		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Stre	et and Number or A	lural Route Numb	er, City o	r Town, State, Zi	ip Code)
and c		Martha Powell/Moth	er	2 Ba	anyan Wo	od Ct., A	pt 302,	Balt	imore, l	Md., 21221
s 1 a f Hei Item othe	- 1	20a. Method of Disposition	20b. P	lace of Disp	osition (Name of matory or other p		Date		ocation - City or T	
nent of t		1 ☐ Burial 2 ☑ Cremation 3 ☐ P * 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	•	REMATORY		10-05	RΔT	TIMORE.	MARYLAND
. 문란를		21. Signature of Fundy Springers		2	2. Name and Add	dress of Facility	77			
Depa Impo any i		1/199	Tun Hay	W	ILLIAM C	BROWN CO	MMUNITY	FUNE	CRAL HOM	E P.A.
夢		23a. Part1. Poter the disease, or compl	ications that caused the deeth					rrest,		Approximate
nysician i		shock, or heart failure. List only or Immediate Cause (Final	Λ		1000		1			Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consequ	JANAK IN	2 92470	iency sy	NAVONAS	2	-	years
caminer			535 (5) 23 2 55/155(1	201100 (1).						•
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uenca of):						
dansit	Examiner	Cause (Disease or injury that initiated events								
ician and burial-transil		resulting in death) Last	Due to (or as a consequ	uence of):						
ysicia ne bu	cai		d							
as th	ledi							1		
as been signed by the attending ph 2 should be detached for use as th	Physician/Med	230. Was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetel		□Ectopic pregna	ncv			23d. Date of deliv	
the att	icie	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at time of de		Other (specify)				Month	Day Year
by the	hys	9 Unknown	9LJ OHKHOWN							
signed d be de	by F	Part II. Other significant conditions con	ntributing to death but not resi	ulting in the u	inderlying cause	given in Part I.	23e. Did 1	tobacco u	ise contribute to	the cause of death?
been si should	ed						10	Yes 2	□ No 3 □ Pro	bably 4. Onknown
2 sh	Completed						24a. Was		24b. Were aut	opsy findings available
te has	E						auto perfe 1 ☐ Yes	ormed?	death?	ompletion of cause of
tor, p	0	25. Was case referred to medical				26. Place of De	eath (Check only		1 103	<i>Ş</i> ₽ 110
r death. ector: After this certificate has been signed by the attending ph by the funeral director, page 2 should be delached for use as the	To B	examiner?	lospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA	04	Home 5 ☐ Resi		6 Other (Speci	m) Hospice
ter th		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. lr	njury at Vork?	28d. Describe			
r: Afl	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(MONIN, Day 16ar)	IIIJuiy		Yes 2 No				
within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st	reet, factory, office	Се	28f. Location (City or To			al Route Number,
24 hours after Funeral Dir tely filled in	Certification:	4 - Homodo	building, stc. (Specif)	"			City of 10	wii, State	,	
nour sners ly fille		29a. Certifier 1 Certifying Phy	sician: To the best of my kno	wledge, dea	th occurred at the	time, date and place	e, and due to the	cause(s)	and manner as	stated.
n 24 he Fu	Medical	(Check only 2 Medical Exami	ner: On the basis of examina and manner stated.	tion and/or in	ivestigation, in m	y opinion, death occ	urred at the time,	date and	place, and due	to the cause(s)
To t	Σ	29b. Signature and title of certifier			29c. Lice	ense number			te signed (Month	
		TIAO MID			D	24170		Fol	ruan 9	, 2005
2		30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type	, Print)		altimor	1 4	7	1
0		E.TSOMO RIZ	ney Hospice	838	N. Ent	awst B	altimor.	L, M	D 212	01
Sta		31. Date filed (Month, Day, Year) FFB - 9 2005	32. Registrar's Signa	ture	de s			/		
Registr	OF	FER = 9.2805	Bellevalle of State	100 100						

10e. Street and Number 1219 Church Street 11. Marital Status 11. Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 2 Married 3 Married 4 Divorced 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 3 Married 3 Married 4 Married 4 Married 4 Married 4 Married 4 Married 5 Married 5 Married 6 Married 6 Married 8					For State Registrar		Maryland / De		of Health and I	Mental Hygi	ene,)5	03868
Single years of consistency of the section of policy for the section o			D1 - 1 - 1		1. Decedent's Name (First, Middle, La	ist)					-	Voca	3. Time of Death
Gilchrist Hospice Contex September Se						Nancy Lee	Ervin			February	3 20	005	9:25 A.M
South Security Number Service Se			Examin	er									
Discourse of the control of the cont										D. D. A. of Dist.	Balt		
10. State 10. Control 10. State 10. Control 10. State 10. Control 10. State 10. Control 10. State 10. Control 10. State 10. Control 10. State 10. Control 10. State 10. Control 10. State 10. Control 10. State 10. Control 10. State 10. Control 10. State 10. Control 10. State 10. Control 10. State 10. Control 10. State 10. Control 10. State 10. Control 10. State 10. Control 10. State 10. Control 10. State 10. Control 10. Contro	E.				214 44 3520			Months [(Month, Day,	1946		
The Second Continued Con	47	/land	Mo.				10c. City, Town or	r Location				10	Od. Inside City Limits
The Secretary Colons Asserting Formation (Colons Formation Science) The Secretary Colons Asserting Formation Science Secretary Colons Asserting Formation Scienc	25	e Man	Ba-f st	ctor			Baltin	ore					1XYes 2 □ No
The Secretary Colons Asserting Formation (Colons Formation Science) The Secretary Colons Asserting Formation Science Secretary Colons Asserting Formation Scienc	0	th with th	23a or 2	ai Dire		eet				10		hat Coun	try?
Physician // Medical Examiner Physician // Medical Examiner	100	r dea	ems er mi	ner	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S. 1	3. Was Deceder	nt of Hispanic Origin? (Sp. Cuban, Mexican, Puerto	pecify Yes or No-			
Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) I ary, leading to immediate (Medical Examiner) Ball (Medical Examiner) Due to (or as a consequence of): D		036 ours afte	ral', or li	by		If Yes, Give	XINo						
Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) I ary, leading to immediate (Medical Examiner) Ball (Medical Examiner) Due to (or as a consequence of): D	8		"natu	lete	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. De	ecedent's Usual (Occupation done during most of work	king			dustry
Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) I ary, leading to immediate (Medical Examiner) Ball (Medical Examiner) Due to (or as a consequence of): D	2	within a	than the M	dwo	Elementary/Secondary (0-12)	College (1-4d							e Store
Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) I ary, leading to immediate (Medical Examiner) Ball (Medical Examiner) Due to (or as a consequence of): D	20	D filled	othar ant,			1)			18. Mother's Nam	ne (First, Middle, Ma			<u>e 5001e</u>
Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) I ary, leading to immediate (Medical Examiner) Ball (Medical Examiner) Due to (or as a consequence of): D	a	rlan	rked tic ev	To B	Jesse W	<i>l</i> atson			Shi	rley Walr	ner		
Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) I ary, leading to immediate (Medical Examiner) Ball (Medical Examiner) Due to (or as a consequence of): D		lary 2 sho	ls ma auma						Street and Number or Ru	ral Route Number,	City or Town, S		
Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) I ary, leading to immediate (Medical Examiner) Ball (Medical Examiner) Due to (or as a consequence of): D	-	e, L	m 27 har tr		· · · · · · · · · · · · · · · · · · ·	son_							
Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) I ary, leading to immediate (Medical Examiner) Ball (Medical Examiner) Due to (or as a consequence of): D	Z.	JOF ages	or of		1 □ Burial 2 🔯 Cremation 3 [
Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) Physician (Medical Examiner) I ary, leading to immediate (Medical Examiner) Ball (Medical Examiner) Due to (or as a consequence of): D	5	Itin	ortant injury				Bayview						
23. Sa Sart. I. Emir the disease, or copy share that caused the death. Do not enter the mode of dying, such as cardae or respiratory arrest, immediate cause (Pinal foundation). Immediate Cause (Pinal foundation	+1	Ba a	and you		1 Kmna M	Inami	isurli		00	once Fune: av Balt	ral Ser imore,	Vice Marv	, P.A. Mand 21225
Physician Medical Examiner Physician Medical Examiner					23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caus						1	Approximate
Medical Examiner Part Par		Phy	sician		Immediate Cause (Final	1 1						1	Onset and Death
Sequencially list conditions, if any, leading to immediate cause. Enter Underlying in favil, leading to immediate cause. Enter Underlying in favil, leading to immediate cause. Enter Underlying in dealth) Last cause of certain in the past its processor as a property of the past its proc						Due to (or						-	000000
The securing in death Last Compared by the securing in death L		LAC	111111111111111111111111111111111111111	_	Sequentially list conditions,	b. Due to (es.	20.000000000000000000000000000000000000						
The securing in death Last Compared by the securing in death L	B	ted	nsit	nlne	cause. Enter Underlying Cause (Disease or injury	D00 t0 (01 a	as a consequence or):						
Second S	4), execu	n and ial-tra	Exar	that initiated events	C Due to (or a	as a consequence of):						
FEMALE: 23d. Date of delivery 23d. Date of deliv		76(te be	ysicia ie bur		(d							
The state of the		rtiffica	ng ph	Medi	IC ECMAI C								
The state of the		30X	tendi or use	lan/I	23b. Was decedent pregnant	1 Live birth	2 Fetal death						*
The state of the cause of death? 1		O. of	the a	yslc	1 ☐ Yes 2 🕱 No			5 Other (spec	ify)		141041		Day Tour
The state of the s		D that	deta		Part II. Other significant conditions	contributing to death	but not resulting in th	e underlying cau	se given in Part I.	23e. Did toba	cco use contri	bute to th	e cause of death?
The state of the s		rds	en sig		COPD					1 Yes	2 🗆 No	3 🗌 Proba	ably 4 Unknown
The state of the s		eco law re	65 (4	plet							24b. W	ere autop	osy findings available
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		— ₽	ate ha	Com						performe	ed? de	eath?	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		/ita	ertific actor,	0						th (Check only one)			
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		of \	this c	-		1 L Inpa			4 U Nursing He		/		nospice
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		ding	After	tlon	1 Natural 5 ☐ Pending		Day Year) 280. Time			28d. Describe how	injury occurre	d	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		/iSi Atten	actor:	fica	3 Suicide 6 Could not b	28e. Place of	Injury - At home, farm,				et and Numbe	r or Rural	Route Number,
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) FUNDARY 3 2005		Div	od in	Sert	4 Homicide	building,	etc. (Specify)			City or Town,	State)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		Hospit 24 hours	etely filk		(Check only / 2 Medical Exa	miner: On the basis	s of examination and/o	eath occurred at r investigation, in	the time, date and place, my opinion, death occur	and due to the cau red at the time, dat	ise(s) and man e and place, a	ner as stand due to	ated. the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		ro tha	To the	Me		aa.mor		29c. L	icense number	290	d. Date signed	(Month, E	Day, Year)
Agans deletares was last of charles at the guard and 212016			,		Man	ans		D	58303	F	elsavier	4	3 2005
State Registrar Apron J. Cutmures W. 660 N. Charles ST Brannone w. 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar			10		30. Name and address of person who	completed cause of	of death (Item 23a) (Type					7	
State State 31. Date filed (Month, Day, Year) 32. Registrar's Signature			۲		111-0. 0.00117-0	S M G	1601 N. CI	rarles	ST BALA	nose we	2120	14	
TT () () () () () () () () () ()		100					strar's Signature	H. Son	while				

		1- For State Registrar	State of Ma		artment of F			giene leg. No A	OC	00000
		Decedent's Name (First, Middle, La	st)				2. Date of Dea	th Em	U 3	3. Time of Death
Physici /Medio		Mary Ely					Jours!	7 31 3	Year	1930 M
Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Dea			ity of Death	
		Union Memorial H	ospital		Ва	altimore			N/A	
Funeral		Social Security Number 6. S	3	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr		1936		lece (State or Foreign
Director		210-33-2040	I□M 2∏F	67 Yrs.			Mar. 7,	1937	111	inois
and *		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				11	0d. Inside City Limits
/anyl	5		.	,					["	1 ☐ Yes 2 X No
28a-	Director	10e. Street and Number	imore	שע Du	ndalk			Iog. Citizen o	f Mhat Cour	to/2
death with the Maryland ms 23e or 28e-f show Lithist be rivilland at	0	7833 Wise Avenue			212)))				
leath ms 20	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S. 13.				United 14.8	ace - America	
or Iter		1 Never Married 2 XMarried	Armed Forces?	10			Specify Yes or No- no Rican, etc.)		ack, White,	etc.
be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or Items 23e or 28a-f show event, It e Medical Eventher rectified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐XNo	Specify:		Spec	ity: Whi	ite
72 ho	Completed	15. Decedent's E- (Specify only highest gra	ducation	16a. Dece	dent's Usual Occup- kind of work done	ation	arkina	16b. Kind of	Business/Ind	lustry
ithin sen *	npie	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retired	()	Siking			
ygier ygier ner th	ပိ	7		Но	memaker		[n Home	2
1 be filed within 72 hatal Hygiene. ed other than "natus event, II a Medica	Be	17. Father's Name (First, Middle, Last,)			18. Mother's Na	ame (First, Middle,	Maiden Suma	ame)	
should be nd Mental marked o	은	Miller Ely				Luba_	DK 595 E-100			*100
12 st hand 7 le n treun		19a. Informant's Name/Relationship (,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Rural Route Number			Code)
ss 1 and 2 should b of Health and Menti litem 27 le marked r other treumatic e		John Ely Husban 20a. Method of Disposition	<u>d</u>	20b. Place of Dispo	sition (Name of		ndalk, MD	21222 20c. Location		um State
ages nt of t: ff lt		1 Burial ∕2 Cremation 3 □		cemetery, crer	natory or other plac					
permit. Pages Department of I Importent: If Its any injury or o		' 4 ☐ Dona ion 5 ☐ Other Specifical Lice.	· · · · · · · · · · · · · · · · · · ·	Western			-2005 mbrose Fu	Balti	more,	MD
Depi Impo		10001 YE	5X1X1/9()				ry Rd., L		.0.5	
200		23a. Part1. Enter the disease, or com	plications that dused	the death. Do not ent					ne, m	Approximate
Observatoria		shock, or heart failure. List only	one cause on each lin	10.				,		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Nems	a consequence of):	ensi (HUCE	\sim		(3 years
Examiner				2 30.100 40.100 617.						
	Jer	fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):						
cuted nd ransi	Examin	Cause (Disease or injury that initiated events	c							
cate be executed physician and the burial-transit	Ë	resulting in death) Last	Due to (or as	a consequence of):						
ate hys the	dicai		d							
	a)	IF FEMALE:								
death certifi e attending id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy				ate of deliver	ry Day Year
that the de led by the a detached t	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5 L	Other (specify)					
that the by detact	Ph.	Part II. Other significant conditions of	contributing to death bu	ut not resulting in the ur	nderlying cause give	en in Part I.	23e. Did tot	nacco use cor	ntribute to the	e cause of death?
w requires that s been signed b should be deta	d by			-	, ,		1 □ Ye	s 20 No	3 Proba	abiy 4 ⊡Unknown
> 9 0	Completed						24a. Was a	- 245	Wasa auton	our findings available
has pe 2	щ						autops	y	prior to com	sy findings available apletion of cause of
	o C	25. Was case referred to medical				00.01 /0	1 Yes	No	1 ☐ Yes 2	2XNo
Physiclan: this certific ral director,	O B	examiner?	Hospital:	nt 2 ☐ ER/Outpatien	t 3 DOA Othe	oc.	ath <i>(Check only on</i> Home 5 Reside		has (Casa) f	,
ding Phy h. After thi funeral o	E I	27. Manner of Death	28a. Date of Injur	y 28b. Time of	28c. Injury	at	28d. Describe ho			/
Attending For death. Sector: After by the funer.	atio	1 Hatural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	Work M 1□	(? Yes 2 □No				
l or Attendi after death. Director: A	tific	3 ☐ Suicide 6 ☐ Could not be determined		iry - At home, farm, str	eet, factory, office		28f. Location (St City or Town		ber or Rural	Route Number,
tal or A rs after al Direc ed in by	Certification;		ballowing, old	(0,000,00)			Oily or Your	i, Siaie/		
e Hospital 24 hours a e Funeral (letely filled	edical	(Check only 2 Medical Exam	niner: On the basis of	of my knowledge, death examination and/or inv	occurred at the time	e, date and plac	e, and due to the ca urred at the time, d	ause(s) and mate and place	nanner as sta	ited. the cause(s)
To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	Med	one) 29b. Signature and title of criffier	and manner sta	ted.	29c. License			9d. Date sign		
F S F S	2	1/2/6	2 1	7.	in ce un	aud	_	-	الارج	
hill		30. Name and address of person o	completed cause of di	eath (Item 23a) (Type,	Print)	177	, ii	nen	7 71	100k
1		myler Walto		3333N C (1966,		t Stree	+ Baltin	DIE X	hda	1218
Sta	te	31. Date filed (Month, Day, Year)	32. Registra	Signature	1 4	- 4-6			, ,	1000
Registr	100	EER O	9 2005	Hearing A.	Broule	V				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Elizabeth 3:30P M 03 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Street Baltimore NIA Kosedale 723 N. If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 84 Yrs. Months Days Hours 191.22.73 1 ☐ M 2 💆 F Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rusedale Street 21216 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 131 a M 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) hant lummer Hughe 19b. Mailing Address (Street and Number or Rural Roule Number, City or Town, State, Zip Code) 723 N. Rosedale Street Hawkins Baltimore MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Baltimore MD 02.10.05 4RBUTUS * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
VOLUMENT C. Creene Funeral Services.
5151 Baltimore Natural Pike Baltimore MD 21229 21. Signature of Funeral Service Licenseau 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COPONARY ARTERY Due to (or as a consequence of): HYPERTENSIO LERDOLL ARTERASC Due to (or as a consequence of)

Physician /Medical Examiner

the attending physician and hed for use as the burial-transit

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

To the Hospital or Attanding Physician:

hours after death.

within 24 hours a

this

After

Diractor:

Physician

/Medical

Examiner

10a. State

Completed by Funeral Director

2

Physician/Medical Examiner

Completed by

Be

2

Certification:

Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --" any injury or other traumatic average.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE 23b. Was decedent pregnant in the past 12 mont 1 Yes 2 No 9 Unknown

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

4 Homicide

1 Natural

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery

Year

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PERIPHERAL VASCOLAR

25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)

28c. Injury at Work? 28b. Time of

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

1 Yes

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2∏No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifier

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

wiens shewe

24a. Was an autopsy performe

1 Yes

2 No

Registrar

2455

Clarence Frazier 05-0456 AKG 1-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

56		For State		/ Depa	artment of Health and Matricate of Death	Mental Hyg	iene	5 03971
		Registrar 1. Decedent's Name (First, Middle, Last,		061	uncate of Death	2. Date of Deat	eg. No UU	03071
Physic /Medi		Clarence Frazie				Month Januar	Day Year	3. Time of Death 5 1:28 P M
Exami		4a. Facility Name (If not institution, give	· ·		4b. City, Town, or Location of Death		4c. County of Dea	ath
		1666 West North Av	enue		Baltimore			
Funeral Director			7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Julu 4,	^{ygar)} 42 9. Bi	rthplace (State or Foreign country) unk
pu *		Usual Residence of Decedent 10a. State 10b. County	10e City	Town and a				
5-UUSD 72 hours after death with the Maryland 72 hours after death with the Maryland neturel', or Items 23a or 28e-f show dical Examiner must be notified at	tor	MD 10a. State 10b. County		Town or Loo Baltin				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
1.28c	ē	10e. Street and Number		· · · · · · · · · · · · · · · · · · ·	10f. Zip Code	1	0g. Citizen of What C	ountry?
3a o	0	1666 W. North Av	enue		21217		USA	,
ns 2	era		12. Was Decedent Ever in U.S.	13. V	_1	ecify Yes or No-	14. Race - Am	erican Indian
r then	Funeral Director	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No 1	ınk	Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whi	ite, etc.
DUCA DOURS a Urel', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2 🕅 No Specify:		Specify:	black
72 7	ete	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Deced	ent's Usual Occupation kind of work done during most of work	unk	16b. Kind of Business	s/Industry un
ING Z1Z13-UU36 be filed within 72 hours after death with the Marylan ltal Hygiene. d other than "neturel", or tiems 23a or 28e-f show event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) unk	College (1-4or 5+)	life. L	OO NOT use retired)			
Maryland 2 d 2 should be filed in the and Mental Hygic 7 is marked other treumatic event, it	Be	17. Father's Name (First, Middle, Last)			unk 18. Mother's Nam	e (First, Middle, M	Maiden Sumame)	unk
re, Marylar s 1 and 2 should be t Health and Menta tem 27 is marked other treumatic ex	5	19a. Informant's Name/Relationship (Ty	no Print)	10h Mailia	- Add (C	-10- 1-11	0: -	
VICE 12 sho h and 7 is m ireum	1 2	O.C.M.E.	pe, Print)		g Address (Street and Number or Rui		City or Town, State,	Zip Code)
C = 61 F	1	20a. Method of Disposition	20h Die	III P	enn Street Baltim		21201	
	1 8	1 ☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☒ Other (Specify)	lemoval from State cen	netery, crem	natory or other place)	Date	20c. Location - City or	Town, State
baltimore, permit. Pages 1 ar Department of Hea importent: If Item any injury or othe		21. Signature of Emeral Service Licens Ronal d S	ade Direct r	St	Name and Address of Facility Late Anatomy Board Oltimore, MD 2120	1 655 W.	Baltimore	Street
Pnysician /Medical Examiner		23a. Pand. Enter the disease, or complete shock or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	cations that caused the death. the cause on each line. Due to (or as a conseque	5)	er the mode of dying, such as cardiac Hue Gwer		est,	Approximate Interval Between Onset and Death
	Examiner	if any, leading to immediate cause. Enter Originally ing Cause (Disease or injury	Due to (or as a conseque	nce of):				
. BOX b8/bU, death certificate be executed e attending physicien and d for use as the burial-transit	ical Exa	that initiated events resulting in death) Last	Due to (or as a consequent	nce of):				
tifica tifica as th								
the death certific by the attending p tached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 🗌	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
S, S es that gned be de	by	Part II. Dther significant conditions cor	ntributing to death but not resulti	ing in the un	derlying cause given in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
	Completed					24a. Was ar autops perform	y prior to ned? death?	utopsy findings available completion of cause of
VICAL sicien: certifical irector, p	Be (25. Was case referred to medical examiner?			26. Place of Deat			
VISION OF VITA Attending Physicien: r death. ector: After this certificity the funeral director.	2	1XXves 2 No	The second secon	VOutpatient	28c. Injury at	me 5 Reside	nce 6XIXOther (Spe	ocity) at scene
VISION OT rAttending Physer death. rector: After this by the funeral di	atior	1 Natural 5 ☐ Pending investigation	28a. Date of Injury 2: (Month, Day Year)	Injury	Work? M 1 Yes 2 No	200. 0000100 110	Williamy Cocumbo	
DIVISIC	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, office	28f. Location (Sti City or Town	reet and Number or R , State)	ural Route Number,
To the Hospitel or within 24 hours after To the Funere Director Completely filled in b	edicai C	29a. Certifier (Check only one) 1 Certifying Physical Exami	sician: To the best of my knowledge: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the ca	use(s) and manner a ate and place, and due	s stated. e to the cause(s)
To 1 To 1	×	29b. Signature and title of certifie	nM		29c. License number O.C.M.E.		od. Date signed (Moni nuary 20,	, ,
		30. Name and address of person who co	mpleted are of death (Item 2	За) (Туре, Р		, ,	, - ,	

DHMH 17 Rev 1/2001

State Registrar S. Q. L+ 31. Date filed (Month, Day, Year)

FEB 0 9 2005

3 Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® For State Registra 03872 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JAN. 27,2005 John Henry Fletcher, Jr /Medical 5-40 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbury Nursing and Rehab Center Wicomico Salisbury, Md. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F Days Director 220-32-9477 67 14, Aug 1937 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 28e-f show 10d. Inside City Limits treumetic event, the Medical Exerciner roust be notified at MD Somerset Director Eden 1 ☐ Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 5 28169 Stanford Road or Items 23a 21822 USA Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: 3 ☐ Widowed 4 X Divorced black. "neturef", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 0 police officer law enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be f Health and Mental H John Henry Fletcher, Sr Clara Nelson ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 I Winnie King/niece 28169 Stanford Road Eden, MD 21822 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages nent of t Department of I Important: If its any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □Donation 5 XOther (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade Director State Anatomy Board 655 W. Baltimore Street water Baltimore, MD 21201 3a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician Head de disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 □ No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 2 No 2 No 1 ☐ Yes 1 🔲 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Trursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2₽No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 Homicide 1 Dertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier/ 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) FEB 0 9 2005

WILLIAM ROBINS,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Signature

200 CIVIC AVE., SALISBURY, MD.

FLETCHER

H.

Box 68760

			For State Registrar	of Maryland / Depa	artment of H			ene 005	03873
	Dhuaisi		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic			razier, JR.	,		February	6 2005	1:43 P. ^M
	Examin		4a. Facility Name (If not institution, give street and n	umber)		Location of Death		4c. County of Death	า
			1639 LOCUST STREET	7 Ann (In our look high door)	BALTTI If Under 1 Year		8. Date of Birth	N/A	nplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) 66 Yrs.	Months Days	Hours Min.	(Month, Day, 1	(ear) Cou	untry)
			219 26 7262 Superior Superior 219 26 Page 1				Aug. 25,	1930 19	entucky
	rylan how		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Ma Ba-f s	cto	Maryland N/A	Balti					tx∏Yes 2 ☐ No
	vith th	Funeral Director	10e. Street and Number		10f. Zip Code	26	10	g. Citizen of What Co	untry?
	sath v	eral	1639 Locust Street	cedent Ever in U.S. 13.	2122		ocify Ves or No-	U.S.	rican Indian
	ter de	Ľ.	Armed I	Forces?	If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.
036	ursal al', o	þ	3 Widowed 4 Divorced If Yes, C	Sive	1⊡Yes 2∏XNo	Specify:		Specify: Whi	.te
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show fre Modicel Examitter must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed	d) (Give	dent's Usual Occup	during most of working	na 11	6b. Kind of Business/I	ndustry
2	ithin e.	npl		(1-4or 5+) life.	DO NOT use retired	d)		ml-:	_
	lled w lygier har ti		12th 17. Father's Name (First, Middle, Last)	Tru	ck Driver	18. Mother's Name	(First Middle M	Trucking	
and	d be funtal Head of	Be c	Flem L.	Frazier			el Hayes	siddir <i>Gamano</i> ,	
Maryland	should bd Me mark imatic	ည	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street a			City or Town, State, Z	lip Code)
	alth a		Evelyn V. Frazier / wi	lfe 1639	Locust S	treet B	altimore	, Maryland	21226
ore,	as 1 a of Hei litam r othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from	20b. Place of Dispo				Oc. Location - City or	
<u>Ë</u>	Page ment ant: It ury o		*4 □Donation 5 □ Other (Specify)	Loudon P	ark Cemet	ery 2/11	/2005	Baltimore,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, It's Medical Examitter must be mittled at once.		21. Signature of Funeral Service Licensee	1. 2	2. Name and Addres	ss of Facility Gon	ce Funer	al Service	. P.A.
	707 4 O		Jecome grander	seed 4	001 Ritch	ie Highwa	y Balti	more, Mary	P.A. land 21225
			23a Fart1. Enter the disease or complications that shock, or heart failure. List only one cause or	^			The second second second		Interval Between Onset and Death
	Prysician /Medical		Immediate Cause (Final disease or condition resulting in death)		OF	THE	LIVER		3 YEARS
ŀ	Examiner			o (or as a consequence of):					
4		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	o (or as a consequence of):					-
	cuted nd iransii	Examiner	Cause (Disease or injury that initiated events c.						
30,	ate be executed physician and the burial-transit	EX	resulting in death) Last Due t	o (or as a consequence of):					
8760,	icate to physic	dical	d						
9 X	death certifics e attending pl d for use as t	Physician/Med	IF FEMALE: 23c. If yes, o	outcome of pregnancy				23d. Date of deli	verv
Вох	death a atter d for u	iciar	In the past 12 months?	gnant at time of death 5 [⊒Ectopic pregnancy ⊒ Other (s <i>pecify)</i>	<u> </u>		Month	Day Year
P.0	tt the by the tache	hys	9 Unknown 9 Unk	known					
		by F	Part II. Other significant conditions contributing to	death but not resulting in the u	inderlying cause giv	en in Part I.		cco use contribute to	-2
ecords,	law requires as been sign 2 should be	ted					1 L Yes	2 No 3 Pro	obably 4 Unknown
ec	has by	Completed					24a. Was an autopsy perform	prior to c	topsy findings available completion of cause of
<u>~</u>	That a se							No 1 ☐ Yes	2 No
Vital	Physician: This certifical	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	☐ Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Oth	er: 4 D Nursing Her	_	ce 6 Other (Spec	w.A.)
of		-	27. Manner of Death 28a. Dat	e of Injury 28b. Time of	11 3 DOX 1	4 Nursing Ho	28d. Describe how		ary)
ion		atlo	1 Natural 5 ☐ Pending (Mit 2 ☐ Accident investigation	onth, Day Year) Injury		Yes 2□No			
Division	l or Attan after deat Diractor:	Certification:	3 Suicide 6 Could not be determined 28e. Pla bui	ce of Injury - At home, farm, st Iding, etc. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	urs aff	Cer							
	Hospital 24 hours a Funaral I itely filled	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To to the 2 Medicel Exeminer: On the and ma	he best of my knowledge, deat basis of examination and/or in anner stated.					
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Med			29c. Licens	e number	290	d. Date signed (Month	n, Day, Year)
	->-0		> wolkle	MD	DIC	0354	Ĩ	EBRUAR	Y 7, 2005
	X		30. Name and address of person who completed ca	use of death (Item 23a) (Type	, Print)	. 0			. ,
			EW COLE ST AGNE	5 900 CA	TON AVE	BALTI	nore 1	40 218	229
	Sta Registr		31. Date filed (Month, Day, Year) 32.	MD use of death (Item 23a) (Type 5 900 CA Registrary signature	. Sperle	9			

Patient Known As Jan Fortune Baltimore Maryland 21215-0036

			Please . For	Type or Prin							-		_		
			1 - State Registrar			Cer	tifica	te of	Death			Reg. N	2005	038	374
	Physicia	an.	1. Decedent's Name (First, Middle, Las	-							2. Date of De Month		ay Year	3. Time o	-
	/Medic		Jan Frances								Februar		3, 2005		PM
	Examin	er	4a. Facility Name (If not institution, give	0 0 1 1			,		r Location o	of Death		′ 4	c. County of Dea	ith	
	Funeral		5. Social Security Number 6.5		(In yrs. last	birthday)	If Unde	r 1 Year	If Under		8. Date of Bi	rth	N/A 9. Bi	thplace (State ountry)	or Foreign
	Director		216-74-0782	□M 2√2 F 4	0	Yrs.	Months	Days	Hours	Min.	ar. 1	а <i>у, Ү</i> өал	1964 N	oun <i>try)</i> Marvlar	nd
	and .		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	cation						THE STATE OF THE S	10d. Inside C	
	ne Maryl 8a-f sho ziffied s	Director	Maryland N/A		-	ltim						-		Х¤Yes	-
	with the	Dire	10e. Street and Number 5406 Denmore A	Vonuo			10f. Z	p Code 212	15				itizen of What C JSA	ountry?	
	ns 23	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. W	Vas Dece			gin? (Spec	ifv Yes or N		14. Race - Am	erican Indian.	
250	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. Hygiene. Add other than "natural", or Itams 23s or 28s-f show avent, the Medical Examinar must be notified at	by	1 ★Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ Ne If Yes, Give Year or Dates:	0			cify Cuba 2[☑ No	an, Mexicar Specify:		ify Yes or Nican, etc.)		Black, Whi Specify: B]		
5	72 hc	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16	6a. Deced	kind of w	ork done	durina mos	t of workin	g	16b.	Kind of Business	/Industry	
7 7	2 should be filed within and Mental Hygiene. Ia marked other than ' aumatic avent, tra Me	Completed	Elementary/Secondary (0-12) 11th grade	College (1-4or 5-	-)	Lab		is <i>e retire</i> d	1)			Pri	lvate I	ndusti	C Y
3	avent,	BeC	17. Father's Name (First, Middle, Last)										n Sumame)		
Y	should I	P	Francis Fortu				1-0.1				Matth				
	s 1 and 2 should f Health and Men itam 27 ia marke other traumatic		19a. Informant's Name/Relationship (Jeanne Matthews	**									or Town, State, ore, Md		5
	permit. Pages 1 and 2 Department of Health a Important: If itam 27 I. any injury or other tra		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ 1 □ Other (Specify		20b. Place ceme Wood]	itery, crem	atory or	other plac	ry	2/12	05		odlawn,		Land
מ	permit. Departr Importa any inja		21. Signature of Funeral Service Life	600									ris Fu		
	nysician /Medical Examiner		23a. Parti. Enter the disease, or common shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a	ell l	o not ente	er the mo						timore	Approximate Interval Bet Onset and	te tween ' Death
-	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequenc	ce of):									
	cate be executed physician and the burial-transit	dical Examiner	Cause (Lissase or Injury that initiated events resulting in death) Last	Due to (or as a	consequenc	ce of):		-							
.O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician to the Funaral Director. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	☐ Fetal dea	ath 3 🗆	Ectopic p Other (s	pregnancy	'				23d. Date of de Month		Year
L (2), L	v requires that been signed t should be det	by P	Part II. Other significant conditions o	ontributing to death but	t not resulting	g in the un	derlying	cause giv	en in Part I.				use contribute to	o the cause of c	
	sician: The law requir certificate has been s' irector, page 2 should	ompleted									24a. Was auto perfe 1 \(\text{Yes} \)		prior to death?	utopsy findings completion of c	available ause of
<u> </u>	ysician: The is certificate had director, page	BeC	25. Was case referred to medical examiner?						26. Place	of Death	Check only		0 1316	222110	
>	Physic this ce al dire	ပ္	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatien		Outpatient			4 140	rsing Hom	e 5⊡Res	idence	6 ☐Other (Spe	ecify)	
5	inding Phy ath. r: After thi	ation;	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b	o. Time of Injury	м	28c. Injur Wor 1 🗆	yat k? Yes 2⊡1	1	3d. Describe	how inju	ury occurred		
	To the Hospital or Attendi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	ry - At home, (Specify)	, farm, stre	et, facto	y, office		28	Bf. Location (City or To		and Number or R te)	u <i>ral Route N</i> um	ber,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of niner: On the basis of and manner stat	examination	dge, death and/or inv	occurred	l at the tin	ne, date an pinion, dea	d place, ar th occurred	nd due to the d at the time,	cause(: date ar	s) and manner a nd place, and du	s stated. e to the cause(s	5)
	To the To the Comp	Me	29b. Signature and title of certifier	7			29	_	e number			29d. Da	ate signed (Mon	th, Day, Year)	
	>	8	Mich & a	up D.O.		<.		RES	5-00	00		Fel	bruciny	3,200	5
7-	1 X		30. Name and address of person who	mpleted cause of de	ath (Item 23a		-1 0		, 0 1						
1	('		Michael Gardy, 31. Date filed (Month, Day, Year)	22. Registra	's Signature	Itos	pital	04	1301	Mucy	ه				
	Sta Registr		FEB 0 9 2005	Maria	K ,	Speed	E .								

State Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 0 0 5 03875 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 9:09 A M Franklin tar February 2005 0 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Johns Baltimore Hopkins Bayview Medical Center If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 78 Yrs. 5. Social Security Number 8. Date of Birth (Month, Day Year) 8-2-1926 9. Birthplace (State or Foreign **Funeral** Hours 212-22-9924 1[XM 2□ F MARYLAND Director Usual Residence of Decedent filed withIn 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23s or 28s-f show traumatic event, if a Madical Examinar must be notified at 1X Yes 2 No MD N/A **HIGHLANDTOWN** Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1641 A ELRINO STREET 21224 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) NATIONAL MOLASSES and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER COMPANY 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be fit ment of Health and Mental H tant: If item 27 is marked otl JOHN E. FRANKLIN **AMELIA** (PICKETT) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD E. FRANKLIN/ SON 1641 A ELRINO STREET BALTIMORE, MD 21224 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. METRO CREMATORY 2-11-2005 CATONSVILLE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Euneral Service Licensee CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MD 23a. Part1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration **Physician** pheumon ia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary artery disease chronic 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed pulmonary disease, 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 Natural 2 Accident 5 Pending Injury 1 Tyes 2 No investigation Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical completely (Check only 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) RES-000 February ddress of person who completed cause of death (Item 23a) (Type, Print) 4940 Baltimore Eastern Avenue · Eckman Registrar's Signature 9 2005 Carren Registrar

			1 – For Stata Registrar		ryland / Depa		of Heal		A	ag. No	005	038	16
Н	Physici	an	1. Decedent's Name (First, Middle, Last, Florence A.						2. Date of Dea Month FEBRUAR	th Day	200 gar	3. Time of De	ath
	/Medic Examin	al	Florence A. 4a. Fecility Name (If not institution, give 5907 ARABIA AVE	Francisco street and number)		_	Town, or Loca	ation of Death			unty of Death	7:33A.	М
	Funeral Director		5. Social Security Number 6. Sec	7. Age	(In yrs. last birthday) 88 Yrs.	If Under Months		Inder 24 Hrs. ours Min.	8. Date of Birth (Month, Day May 26	Year) 1916	9. Birth	place (State or Fo ntry) /land	oreign
	e Maryland la-f ehow	ctor	10a. State 10b. County MD N/A		10c. City, Town or Lo Baltimore	ocation						10d. Inside City L	
	3a or 28	I Dire	10e. Street and Number 5907 Arabia Avenu	ıe		10f. Zip	Code 1214		1	0g. Citizen	of What Cou	ntry?	
9800	iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Heath and Menta! Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f ehow or other traumatic event, the Medical Examinar must be notified at	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates:	0	Was Decedif Yes, spec		ic Origin? (Spexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Amen Black, White, ecify:		
21215-0036	filed within 72 h Hygiene. Ather than "natu	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e co <i>mpleted)</i> College (1-4or 5+	(Give	dent's Usual kind of wor DO NOT usi Homem		most of work	sing		of Business/Ir	,	
Maryland 2	12 should be filed within h and Menta! Hygiene. 7 is marked other than "traumatic event, the Men	To Be C	17. Father's Name (First, Middle, Last) John Jacob Luby	2-6-6-			F	lorenc		Maiden Sun erfiel	name) . d		
	1 and 2 sho Health and tem 27 is m		Mrs. Nancy Bledsoe 20a. Method of Disposition	•		Trian	dos Dr	ive T	i monium,	Mary		21093	
Baltimore,	Pages nent of I int: If it		1 Donation 5 □ Other (Specify)	Removal from State	Parkwood	natory or ot	her place)		9,2005 E		•		
Balti	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service Licens	• Heather	Cain 22	. Name and	Address of F	acility Le	onard J. altimore	Ruck	, Inc.		
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):		2 1.		ula I	Diseco	exl	Approximate Interval Betwee Onset and Dea	
.O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 9 \(\text{Unknown} \)	dd. 3c. If yes, outcome o 1	f pregnancy	Ectopic pre					Date of delive	ery Day Year	
Q	tuires that the signed by ald be detacted	by	Part II. Other significant conditions cor	ntributing to death but	not resulting in the u	nderlying ca	use given in F	Part I.	23e. Did tot	-		ne cause of death	
Vital Records,		Completed							24a. Was a autops perform	y	prior to co death?	psy findings avai mpletion of cause 2 No	
Vita	Physician: Th this certificate ral director, paç	To Be	25. Was case referred to medical examiner? **TOW'es 2 \[\] No	fospital: 1 ☐ Inpatien	t 2 ☐ ER/Outpatien	t 3 🗆 DO/	04		h <i>Check onl on</i> me 5 ☐ Reside		Other /Carri	CCENE	
sion of	ing After une		27. Manner of Death 12 Natural 5 Pending investigation	28a. Date of Injury (Month, Day	28b. Time of		lc. Injury at Work?	-	28d. Describe ho			NOCENE	
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, str (Specify)	eet, factory,	office		28f. Location (St. City or Town		imber or Rura	I Route Number,	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying Physical Control Check only 2 Medical Examination	sician: To the best of ner: On the basis of a and manner state	my knowledge, death examination and/or invegd.	occurred a restigation,	t the time, dai	te and place, , death occurr	and due to the ca red at the time, da	luse(s) and ate and plac	manner as s ce, and due to	tated. the cause(s)	
)	To the complet	Me	29b. Signature and title of genefier	will			License num	ber		_	gned (Month, RY 7,20		
_	5	2.2	30. Name and address of person who co	AND		11			t Baltir	nore,	Maryla	and 2120	1
	Sta Registr		31. Date filed (Manual Year)	32.	's Signature		FEB 0	9 2005	Been	K	hour	35	

ORIGINAL

			1 - For State Registrar	State of Marylar		ment of He		Mental Hygie	ne 2005	03877
	Physic		1. Decedent's Name (First, Middle, La	cick			-	2. Date of Death Month	Day Year 7 2025	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give	1.0	41	o. City, Town, or	Location of Deat		4c. County of Death	12(1
		Ш		Parte wore	for a film () If	Baltim			Baltin	
	Funeral Director		5. Social Security Number (2):	Sex 1 M 2 XF Age (In yrs.		onths Days	If Under 24 Hrs Hours Min.		9. Birth	place (State or Foreign intry)
	pur *	,	Usual Residence of Decedent 10a. State 10b. County	100 0	ty, Town or Locati	on.		Septer 1)	7301 711	giiia
	Manyie -f sho	ξ	Maryland A//	4 7	2014	MAKA				10d. Inside City Limits 1 XYes 2 No
	or 288	Directo	10e. Street and Number	^	20111	10f. Zip Code		10g.	Citizen of What Cou	intry?
	eath w	erai	320/ Avon	A VENUE	15 13 Wee	2/2	218		USF	t
9	after d	Funerail	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Yes 2 No If Yes, Give	If Ye	- 1		specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White	
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, tra Medical Examinational periodities at	Completed by	3 Widowed 4 □ Divorced	Year or Dates:		Yes 2 No	Specify:		Specify: B	ack
215-	nin 72 In "nat	piete	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give kind	's Usual Occupat i of work done du NOT use retired)	tion uring most of wo	rking	o. Kind of Business/Îr	ndustry
2	filed within Hygiene. Ither than "	Com	6		1 Hoi	nemo	eker		Own	Home
Maryland	uid be fil fental H rked ott	Be	17. Father's Name (First, Middle, Last	loody			18. Mother's Nai	me (First, Middle, Mai	den Sumame)	
aryl	2 should and Men is marke	2	19a. Informant's Name/Relationship (Type, Print) Haughter	19b. Mailing A	ddress (Street ar	nd Number or Ri	iral Route Number, C	ity or Town, State, Zij	o Code)
-	and 2 lealth a m 27 is		Mrs. Brenda	Wheeler	320	LAVO	n Au	enue B	alto. Ma	1.21218
nore	00		20a. Method of Disposition 1 Burial 2 Cremation 3 C	Removal from State	Place of Dispositio cemetery, cremato	n (Name of ory or other place,	2/1	3/2000 7	. Location - City or T	own, State
Baltimore	그 돈 뿐 중		21. Signature of Funeral Service Lice		INITY (emete ame and Address	of Facility	- 2005 J	Jundal	K, Ma.
ä	permi Depa Impo any ir		Joseph	J. Kus	1 205	eph Ni	KYSS.	tunera	Home to. Ma. 2	12.16
			23a. Part 1/Enter the disease, or com shook, or heart failure. List only Immediate Cause (Final	plications that caused the deat one cause on each line.	h. Do not enter th	e mode of dying.	, such as cardia	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Ovas	uence of):	ncer				
	Examiner	.	Sequentially list conditions,	b				·		
	uted 3 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uen <i>ce</i> of):					
o,	The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):			-		
8760,	physics the bits the bits	Physician/Medical		d						
Box 6	death certifica attending ph d for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of delive	erv
	e death	sicia	in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		opic pregnancy ner (specify)			Month	Day Year
P.0	res that the de signed by the a be detached f		Part II. Other significant conditions	contributing to death but not res	ulting in the under	lving cause given	in Part I.	23e. Did tobaco	co use contribute to the	ne cause of death?
Records,	w requires been sign should be	ed by						1 ☐ Yes		pably 4 Minknown
eco	e law re has bee je 2 sho	Completed						24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
al B								performed 1 ☐ Yes	? death? No 1 \sum Yes	2/2/20
of Vital	S D	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other	3 3	th (Check only one)	6 ☐Other (Specifi	v)
	ng Pt fter tt ineral	on: T	27. Manner of Death 1. Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c, Injury a Work?		28d. Describe how in		<u> </u>
Division	Attending it death. sctor: After by the fune	ficati	2 Accident investigation 3 Suicide 6 Could not b				s 2 No	28f. Location (Street	and Number or Rura	J Route Number
Οį	s after s after al Dire	Certification;	4 ☐ Homicide determined	building, etc. (Specif	y)	idolory, omos		City or Town, St	ate)	i riobie ivainbei,
)	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death occ tion and/or investi	curred at the time gation, in my opir	, date and place nion, death occu	and due to the cause rred at the time, date :	e(s) and manner as st and place, and due to	ated. the cause(s)
	within 7 to the To the comple	Med	29b. Signature and title of certifier	and marrier stated.		29c. License r	number	29d.	Date signed (Month,	Day, Year)
			I pardi	1		0005	9423	Fe	bruary 7	2005
			30. Name and address of person who	do c 101	Type, Print	26 0	0 -0 -	Fe 323 B. Ctm		17 %
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture ture	Atginal &	Sexton -	505 Bulton	more, kd) 2	-1424
	Registi	ar	FFR - 9 2005	Beneral &	Careta)					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of	Marylar		artment <i>rtificate</i>				ntal Hy	giene Reg. NZ () (15	03070
			1. Decedent's Name (First, Middle, L.	ast)						2	. Date of De	ath	J U	3. Time of Death
	Physici /Medi		Edward Ga	15						J	Month Moval	4 29 2	Year	2:35 Am
)	Examir		4a. Facility Name (If not institution, gi					4b.	City, To		tion of Deat	h 4c. Count	y of Death	
			Franklin Squa	Re NUI	Sing F	and Re	harb	13	9/1	more	: City	13911	rent	re Elly
	Funeral Director				7. Age (In yrs. 66		If Under 1		f Under a Hours	24 Hrs. 8 Min.	Date of Bi Month, Di Sept	I, Year)	9. Birthpl Coun Mary	lace (State or Foreign try) Land
	pun M		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	nation							
	Aaryli f sho	5	MD		100.01	•	imore						18	0d. Inside City Limits 11☑ Yes 2☐ No
	288-	Director	10e. Street end Number				10f. Zip C	ode				10g. Citizen of	What Cour	
	3e or	<u></u>	1217 W. Fayet	te Stree	et				2122	23			USA	uyr
	ms 2	Funeral	11. Marital Status	12. Was Dece	dent Ever in U	,S. 13. 1	Was Decede	nt of Hispa	anic Orig	gin? (Specif	y Yes or No)- 14. Ra	ce - America	an Indian,
Baltimore, Maryland 21215-0020	ges 1 and 2 should be filed within 72 hours efter death with the Maryland to f Health end Mentel Hygiene. If Item 27 is marked other then "naturel", or Items 23e or 28e-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	Armed For 1 Pyes If Yes, Give Year or Da	2 □ No		fYes, specif 1□Yes 2		Mexican Specify:	, Puerto Rio	can, etc.)	Bla Specii	ck, White, 6 fy: b	etc. 1ack
Ŏ	nature	Be Completed	15. Decedent's E	ducation		16a. Deced	dent's Usual	Occupation	on .			16b. Kind of B	lusiness/Ind	lustry
21	en "n	를	(Specify only highest gr Elementary/Secondary (0-12)	ede completed) College (1-	4or 5+)	(Give life. I	kind of work DO NOT use	done duri retired)	ing most	of working				
7	filed wi Hygien other th	ည် ပ	14	0		pipe	layer	:				water	depa	rtment
ğ	be fill d oth	Be	17. Father's Name (First, Middle, Las	")			υ	ınk 18	3. Mothe	r's Name (F	First, Middle	, Maiden Surnai	ne)	unk
<u> </u>	should be fand Mentel Is marked of	2												
Z Z	d 2 sh h end 7 is m traum		19a. Informent's Name/Relationship Molly Smith/care									er, City or Town		
ō,	1 and Health em 27 other tr		20a. Method of Disposition	giver	20b. F	1902 Place of Dispo	N • W a	ashin	igtor	n Stre	et Ba	ltimore	, MD	21213
ē	Pages nent of I nt: If ite iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from S	tate	emetery, crer	natory or oth	er place)		1	Date	200. LUCATION	- City or To	wn, State
	ortant		4 □ Donation 5 ☑ Other (Speci	2000	/	20	Name and	Addross	of Equilib					
Ba	permit. Pages Depertment of important: If it any injury or o		21. Signeture of Funeral Service Lice KODALD S	Wade, D	irecto	r Ś	tate A	nator	my B	oard	655 W	. Baltir	nore S	Street
			23a Part 1 Enter the disease or com	opication that ca	used the deat		altimo			21201				
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on ea	ch line.	n. Do not sin	er the mode	or dying, s	suci i es c	cardiac or n	espiratory a	11651,	1	Approximate Interval Between Onset and Death
)	/Medical		Immediate Cause (Final disease or condition											1-10.
	Examiner	ē	resulting in death)	a	Due to (o	enno or as a conseq	y CC						i	1 cras
	ъ .≅	iner		. 17	2000	870	1.2	A	Oon.	100	100	noms	2	
	and trans	Examiner	Sequentially list conditions,	b	Due to (o	r as a conseq	uence of):	1			700	1 Coffe Co	5	
60,	be ex		Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	C										
28760	ficate be executed physician and is the bunal-transit	edicai	thet initieted events resulting in deeth) Last		Due to (o	r as a conseq	uence of):			-				-
			L L	d										
Box	death cert	Physiclan/M	Death Other death and state											
o.	the cy by the achec	hysi	Part II. Other significant conditions	ontributing to dea	ith but not resi	afting in the ur	nderlying cau	se given i	in Part I.					the cause of death?
ري ح	res thet the de signed by the a I be detached I	by P									10	Yes 2□ No	3 L Prob	ably 4 ☐ Unknown
Ital Records,	- 00										24a. Was	an autopsy		re autopsy findings ilable prior to
ပ္ထ		Completed									pend	rmed?	com	pletion of cause eath?
ř	0 - 7	ĕ									1 🗆 '	Yes 212No	10	Yes QNo
<u> </u>	ysician: The s certificate director, pag	Be	25. Was case referred to medical examiner?					26	6. Plece	of Death (C	check only o	nne)		,
<u> </u>	hysic his ce	ဥ	1 Yes 2 No		patient 2 🗆	ER/Outpatien	t 3□ DOA	Other:	& DYNUC	sing Home	5 ☐ Resid	dence 6 □Oth	er (Specify))
Ē	ding Phy	ä	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28e. Dete of (Month	Injury , Day Year)	28b. Time of Injury		. Injury at Work?			l. Describe i	now injury occur	red	
<u>8</u>	Attending Physician: or death. sector: After this certific by the funeral director,	cati	2 Accident investigatio 3 Suicide 6 Could not b				М		2 □ N					
=	7 # # S	Certification:	4 ☐ Homicide determined	200. Place C	of Injury - At ho g, etc. <i>(Specif</i> y	ome, tarm, stre	eet, factory, c	ffice		281.	City or To	Street and Numb vn, State)	er or Rurei	Route Number,
	he Hospital of the Function of	edicai	29a. Certifier	nysician: To the base and manner	is of examinat	wledge, death ion and/or inv	occurred et restigation, in	the time, o my opinio	date and on, death	place, and n occurred	due to the at the time,	cause(s) and ma date and place,	anner as sta and due to t	ited. the cause(s)
	To the within 2 To the comple	Σ	29b. Signature end title of certifier	***************************************			29c. L	icense nu	ımber			29d. Date signe	d (Month, D	ley, Year)
			1	6			/	19	200	14		1/24	18	
•			30. Name end eddress of person who	completed cause	of death (Item	23a) (Type, I	Print)			2	1		7/3	often
			21 Date filed Weath Day	m	ninten in Ci	2117	Ha	mm	mo	50	TV	Des 126	M	Dams
	Sta	te	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ure							,	20

DHMH 16 Rev 6/95

December Name Trick Addison, Law Service Cord of G. Greenstreet Personary 4 2005 3, 1 through 1 3				1 - For State Registrar	State of Marylan			of Health an		giene Reg. No.	2005	03880
Scanning 4. Facility Name (Proc Setables) year used early and a minuted procession of Date Annual Artundes (Modical Canter Procession) 5. Setables of Section (Proc Setables) year used and the procession of Date Annual Artundes (Modical Canter Procession) 5. Setables of Section (Modifical Canter Procession) 5. Setables of Section (Modifical Canter) 7. Setables of Section (Modifical Canter) 8. Setables of Section (Modifical Canter) 8. Setables of Section (Modifical Canter) 8. Setables of Section (Modifical Canter) 8. Setables of Section (Modifical Canter) 8. Setables of Section (Modifical Canter) 8. Setables of Section (Modifical Canter) 8. Setables of Section (Modifical Canter) 8. Setables of Section (Modifical Canter) 8. Setables of Section (Modifical Canter) 8. Setables of Section (Modifical Canter) 8. Setables of Section (Modifical Canter) 8. Setables of Section (Modifical Canter) 9. Setables of Section (Modifical Canter) 9. Setables of Section (Modifical Canter) 9. Setables of Section (Modifical Canter) 9. Setables of Section (Modifical Canter) 9. Setables of Section (Modifical Canter) 9. Setables of Section (Modifical Canter) 9. Setables of Section (Modifical Canter) 9. Setables of				1. Decedent's Name (First, Middle, Last)							Year	3. Time of Death
## Country Olizant Foundable Fo		_		Go	rdon G. Greer	street	5		Februa	ry 4	2005	8:43 A. M
Social Security Number 0.5 see 1.0 see				The state of the s				_	eath			
218 28 1692 What Provided the Company of the Compan												
The State State				218 28 1682 ¹ 🖫	M 20 E	•			Ain. (Month, Da	y, Year) 26,1		
Signature Market 200 Marries (Parket Market 200 Marries (Parket 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Marries (Parket Market 200 Marries (Parket Marrie		lend wo			10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
Signature Market 200 Marries (Parket Market 200 Marries (Parket 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Marries (Parket Market 200 Marries (Parket Marrie		Mary -t eh	tor	Maryland Anne Aru	ındel L	inthic	um					1 ☐ Yes 2X No
Signature Market 200 Marries (Parket Market 200 Marries (Parket 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Marries (Parket Market 200 Marries (Parket Marrie		r 28e	rec	10e. Street and Number			10f. Zip Co	de		10g. Citi	zen of What Cou	ntry?
Signature Market 200 Marries (Parket Market 200 Marries (Parket 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Market 200 Marries (Parket Marries (Parket Market 200 Marries (Parket Marrie		th wit	a	706 Greentree Roa	ad		2.	1090			U.S.	
Special part Spec		sep .	Iner	11. Marital Status		S. 13.	Was Decedent	of Hispanic Origin' Cuban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	-		
Special part Spec	030	ours efte	by		1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Kore							
17. Fairer's Name (Piez, Michie, Lard) 18. Mother's Name (Piez, Michie, Lard) 19. Mother's Name (Piez, Michie, La	် ဂ	N C = 1	etec			16a. Dece	dent's Usual O	ccupation	working	16b. Ki	nd of Business/Ir	ndustry
17. Fairer's Name (Piez, Michie, Lard) 18. Mother's Name (Piez, Michie, Lard) 19. Mother's Name (Piez, Michie, La	N	ithln 38.	Jqr.	Elementary/Secondary (0-12)	·				,	Co	wrian Ci	hatian
Bernard Greenstreet Theresa (not available Theresa (not available Theresa (not available Theresa (not available Theresa (not available Theresa (not available Theresa (not available) The Maining Address (Sinet and Number or Plazal Rouse Number, City or Town, State, 2p Contect Town All Contents on The Town, State, 2p Contents on The State (Sinet and Number or Plazal Rouse Number, City or Town, State, 2p Contents on The State (Sinet and Number or Plazal Rouse Number, City or Town, State (Sinet and Number or Plazal Rouse Number, City or Town, State (Sinet and Number or Plazal Rouse Number, City or Town, State (Sinet and Number or Plazal Rouse Number, City or Town, State (Sinet and Number or Plazal Rouse Number, City or Town, State (Sinet and Number or Plazal Rouse Number, City or Town, State (Sinet and Number or Plazal Rouse Number, City or Town, State (Sinet and Number or Plazal Rouse Number, City or Town, State (Sinet and Number or Plazal Rouse Number, City or Town, State (Sinet and Number or Plazal Rouse Number, City or Town, State (Sinet and Number or Plazal Rouse Number, City or Town, State (Sinet and Number or Plazal Rouse Number, City or Town, State (Sinet and Number or Plazal Rouse Number, City or Town, State (Sinet and Number or Plazal Rouse Number, City or Town, State (Sinet and Number or Plazal Rouse Number, City or Town, State (Sinet and Number or Plazal Rouse Number, City or Town, State (Sinet and Number or Plazal Rouse Number, City or Town, State (Sinet and Number or Plazal Rouse Number, City or Town, State (Sinet and Number or Plazal Rouse Number, City or Town, State (Sinet and Number or Rouse) Rouse Number, City or Town, State (Sinet and Number or Rouse) Rouse Number, City or Town, State (Sinet and Number or Rouse) Rouse Number, City or Town, State (Sinet and Number or Rouse) Rouse Number, City or Town, State (Sinet and Number or Rouse) Rouse Number, City or Town, State (Sinet and Number or Town, State or Rouse Number, City or Town, State (Sinet And Number or Town, State or Town, State or R	7	led w tygler her ti				Set	т епрт	-	Name (First Middle			tation
Dorothy Greestreet / wife 706 Greentree Road Linthicum, Maryland 21090 Data Commission (Name) Data Commission (Name) Data Commission (Name) Data Commission (Name) Data Commission (Name) Data Commission (Name) Data Commission (Name) Data Commission (Name) Data Dat	/land	uld be fi Mental H Irked of	00		Greenstreet					Maiden		available)
20. Memoral of Deposition in Space of Deposit	a.	2 sho end ie ma										
1.5 Burnal 2 Cornantion 3 Parinval from State 2.9 2005 Glen Burnie, Maryland 2.5 Signature of Funeral Service, P.A. 4.00 Ritchie Funeral Service, P.A. 4	2	and leelth m 27 her tr		-	· · · · · · · · · · · · · · · · · · ·							
22. Name and Address of Facility Gonce Funeral Service, P.A. 4.001 Ritchies Highway Baltimore, Maryland 21.225 Brivstoan Brivstoan Modical Examiner Brivstoan Modical Examiner Brivstoan Modical Examiner Brivstoan Modical Examiner Brivstoan Modical Examiner Brivstoan Brivstoan Modical Examiner Brivstoan Bri	Ö	t of H tf ite or ot			emoval from State	emetery, crer	natory or other	place)			-	
Physician / Micdical Examiner 20 Physician / Micdical Examiner 20 Physician / Micdical Examiner 20 Physician / Micdical Examiner 20 Physician / Micdical Examiner 20 Physician / Micdical Examiner 20 Physician / Micdical Examiner 20 Physician / Micdical Examiner 20 Physician / Micdical Examiner 20 Physician / Micdical Examiner 20 Physician / Micdical Examiner 20 Physician / Micdical Examiner 20 Physician / Micdical Examiner 21 Physician / Micdical Examiner 22 Physician / Micdical Examiner 23 Due to (or a sa consequence of): 24 Physician / Micdical Examiner 25 Physician / Micdical Examiner 26 Physician / Micdical Examiner 27 Physician / Micdical Examiner 28 Physician / Micdical Examiner 28 Physician / Micdical Examiner 28 Physician / Micdical Examiner 28 Physician / Micdical Examiner 28 Physician / Micdical Examiner 28 Physician / Micdical Examiner 28 Physician / Micdical Examiner 29 Physician / Micdical Examiner 29 Physician / Micdical Examiner 20 Physician / Micdical Examiner 20 Physician / Micdical Examiner 20 Physician / Micdical Examiner 20 Physician / Micdical Examiner 20 Physician / Micdical Examiner 20 Physician / Micdical Examiner 20 Physician / Micdical Examiner 20 Physician / Micdical Examiner 20 Physician / Micdical Examiner 21 Physician / Micdical Examiner 22 Physician / Micdical Examiner 23 Substitution Physician / Micdical Examiner 24 Michigan Physician P		C 60 3										-
Physician Middical Examiner The Country of Part I willing in death) The Country of Part I willing in death) The Country of Part I willing in death) The Country of Part I willing in death) The Country of Part I willing in death) The Country of Part I willing in death) The Country of Part I willing in death) The Country of Part I willing in death) The Country of Part I willing in death) The Country of Part I willing in death) The Country of Part I willing in death) The Country of Part I willing in death of delivery The Country of Part I willing in death of delivery The Country of Part I willing in death of delivery The Country of Part I willing in death of delivery The Country of Part I willing in death of delivery The Country of Part I willing in death of delivery The Country of Part I willing in death of delivery The Country of Part I willing in death of delivery The Country of Part I willing in death of delivery The Country of Part I willing in death of delivery The Country of Part I willing in death of delivery The Country of Part I willing in death of delivery The Country of Part I willing in death of delivery The Country of Part I willing in death of delivery The Country of Part I willing in death of delivery The Country of Part I willing in the underlying cause given in Part I. The Country of Part I willing in the underlying cause given in Part I. The Country of Part I willing in the underlying cause given in Part I. The Country of Part I willing in the underlying cause given in Part I. The Country of Part I willing in the underlying cause given in Part I. The Country of Part I willing in the underlying cause given in Part I. The Country of Part I willing in the underlying cause given in Part I. The Country of Part I will not be a will not be a will not be a willing in the underlying cause given in Part I. The Country of Part I will not be a will not be a will not be a will not be a willing in the underlying cause given in Part I. The Country of Part I will not be a will	n n	Departition of the control of the co		Jerre 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2	moustre	4(001 Rit	chie High	Gonce Fun way Bal	eral timo	Service re, Mar	e, P.A. yland 21225
Due to (or as a consequence of): Continued to the past 12 months? Due to (or as a consequence of):				mock, or heart failure. List only one	eations that caused the death e cause on each line.	Do not ent	er the mode of	dying, such as car	diac or respiratory ar	rest,		Interval Between
Sequentially list conditions, if any, leading to mimediate class. Entire Underlying Class British British Underlying Class British Underlying Clas		/Medical		disease or condition	Due to (or as a conseq	uence of):	1480					i eaks
The search of th			_	Sequentially list conditions, b.	Due to (or as a consequ	Hance of):	lure					years
The search of th		pet nslt	nlne	cause. Enter Underlying Cause (Disease or injury	1	12-1-	b.A)	Fail				weeks
FFEMALE: 236. Was decedent pregnant 1 Live birth 2 Felal death 3 Ectopic pregnancy 1 Live birth 2 Felal death 4 Pregnant 1 Live birth 2 Felal death 4 Pregnant 1 Live birth 2 Felal death 4 Pregnant 1 Live birth 2 Felal death 4 Pregnant 1 Live birth 2 Felal death 4 Pregnancy 2 Felal death 4 Pregnancy 2 Felal death 4 Pregnancy 2 Felal death 4 Pregnancy 2 Felal death 4 Pregnancy 2 Felal death 4 Pregnancy 2 Felal death 4 Pregnancy 2 Felal death 4 Pregnancy 2 Felal death 4 Pregnancy 2 Felal death 4 Pregnancy 2 Felal death 4 Pregnancy 2 Felal death 4 Pregnancy 2 Felal death 4 Pregnancy 2 Felal death 4 Pregnancy 2 Felal death 4 Pregna	Ď,	e execuien end urlai-tra		that initiated events C.		uence of):	, (4)	,(/)				
25. Was case referred to medical examiner? 1 Yes 2 No 3 Probably 4 Month Day Year 2 No 3 Probably 4 Month Day Year 2 No 3 Probably 4 Month Day Year 2 No 3 Probably 4 Month Day Year 2 No 3 Probably 4 Month Day Year 2 No 3 Probably 4 Month Day Year 2 No 3 Probably 4 Month Day Year 2 No 3 Probably 4 Month Day Year 2 No 3 Probably 4 Month Day Year 2 No 3 Probably 4 Month Day Year 2 No 3 Probably 4 Month Day Year 2 No 3 Probably 4 Month Day Year 2 No 3 Probably 4 Month Day Year 2 No 3 Probably 4 Month Day Year 2 No 3 Probably 4 Month Day Year 2 No 3 Proba		flicate by g physic as the bi		d.								
The second of th	×	n cert anding use a	n/M				7e			2	3d. Date of deliv	ery
The second of th		he death the atte	ysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de						Month	Day Year
The second of th	ກ໌ ກໍ	es thet t gned by be detac	by Ph	Part II. Other significant conditions cont	ributing to death but not resi	ulting in the u	nderlying cause	given in Part I.	23e. Did to	obacco u	se contribute to t	he cause of death?
The second of th	D.C	pino pino pino pino	ted	Trioresia C.	2017				- 10Y	es 2	JNo 3 ☐ Prot	pably 4 Doknown
28. Place of Death (Check only one) 28. Place of Death (Injury at work? 1 Yes 2 No 28. Place of Death (Injury at work? 1 Yes 2 No 28. Place of Death (Injury at work? 1 Yes 2 No 28. Place of Death (Injury at work? 28. Place of Death (Injury at work? 28. Place of Death (Injury at work? 28. Place of Death (Injury at work? 28. Place of Death (Injury at work? 28. Place of Death (Injury at work? 28. Place of Death (Injury at work? 28. Place of Death (Injury at work? 28. Place of Death (Injury at work? 28. Place of Death (Injury at work? 28. Place of Death (Injury at work? 28. Place of Death (Injury at work? 28. Place of Death (Injury at work?	ပ်	taw tas b	nple						— autop	sy	prior to co	ppsy findings available impletion of cause of
28. Place of Death (Check only one) 28. Place of Death (Injury at work? 1 Yes 2 No 28. Place of Death (Injury at work? 1 Yes 2 No 28. Place of Death (Injury at work? 1 Yes 2 No 28. Place of Death (Injury at work? 28. Place of Death (Injury at work? 28. Place of Death (Injury at work? 28. Place of Death (Injury at work? 28. Place of Death (Injury at work? 28. Place of Death (Injury at work? 28. Place of Death (Injury at work? 28. Place of Death (Injury at work? 28. Place of Death (Injury at work? 28. Place of Death (Injury at work? 28. Place of Death (Injury at work? 28. Place of Death (Injury at work? 28. Place of Death (Injury at work?	=	The cate h	Con								death? 1 ☐ Yes	2)
1 Yes 2 28a. Date of Injury of I	715	ician sertific ector,	0	examiner?	anatal:			Oit				
State	0	d s	\vdash	TE THIS ZENIE	1 panapatient 2			4 🔲 Nursin		_		(y)
286. Place of tripluy At nome, farm, street, factory, office 287. Location (Street and Number of Hural House Number) 288. Place of tripluy At nome, farm, street, factory, office 289.		ling After une	on	1 Natural 5 □ Pending	(Month, Day Year)				28d. Describe n	iow injury	occurred	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature/one/itle of certify 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar' Signature 33. Date filed (Month, Day, Year) 34. Date filed (Month, Day, Year) 35. Registrar' Signature	<u>s</u>	death death stor: / the	cat	3 Suicide 6 Could not be	28e Place of Injury - At ho	me farm str			28f Location (S	Street and	Number or Rus	al Route Number
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of centers of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of centers of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of centers of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who cause (Item 23a) (Type, Print) uncle the fire of person who cause (Item 23a) (Type, Print) uncle the fire of person who cause (Item 23a) (Type, Print) uncle the fire of person who cause (Item 23a) (Type, Print) uncle the fire of person who	2	tei or A rs efter af Directed in by	O	4 Homicide determined			eer, raciory, on	ice			Trumber of Autz	ar Abbite Multiber,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of centers of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of centers of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of centers of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who cause (Item 23a) (Type, Print) uncle the fire of person who cause (Item 23a) (Type, Print) uncle the fire of person who cause (Item 23a) (Type, Print) uncle the fire of person who cause (Item 23a) (Type, Print) uncle the fire of person who		Ne Hospi	dical	(Check only 2 Medical Examin	er: On the basis of examinal							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of centers of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of centers of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of centers of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who completed cause of death (Item 23a) (Type, Print) uncle the fire of person who cause (Item 23a) (Type, Print) uncle the fire of person who cause (Item 23a) (Type, Print) uncle the fire of person who cause (Item 23a) (Type, Print) uncle the fire of person who cause (Item 23a) (Type, Print) uncle the fire of person who		To th Withir To th Comp	Me	29b. Signature and little of certified	1) 1,0		29c. Lic	cense number	r i	29d. Date	signed (Month,	Day, Year)
State 31. Date (iled (Month, Day, Year) 32. Registrar Signature		(,		Me Chas	y Mi		Di	435 44	4	2	14/200	5
		6+1		30. Name and address of person who com	npleted cause of death (Item	23a) (Type,	PHAN	role! V	hedica)	1	enten	
							Some	w				

			_	State of Marylan	d / Depa		alth and M	ental Hyg	_	5 02001
	Physici		Decedent's Name (First, Middle, Last) Gwendolyn Marie	Geter				2. Date of Dea Month		3. Time of Death 5 12:3c PM
	/Medic Examin		4a. Fecility Name (If not institution, give st. Union Memorial			4b. City, Town, or Loc Baltimor		CBrow	4c. County of De	
ı	Funeral Director		Social Security Number 6. Sex	7. Age (In yrs. 53	last birthday) Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 2	9. B (2, 1951 N.	irthplece (State or Foreign Country) Carolina
	aryland show	ŏ	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo	1	y, Town or Lo	ocation odlawn				10d. Inside City Limits 1 ☐ Yes ※※ No
	with the N Se or 28e-1 I be notifi	Funeral Director	10e. Street and Number 3721 Washington	Avenue	.,	10f. Zip Code 21244			10g. Citizen of What (Country?
020	d 2 should be filed within 72 hours after death with the Maryland than death Hygiene. 71 is marked other than "naturel" or Items 23a or 28e-f show traumatic event, it a Medical Examinar must be notified at	by Funera		2. Was Decedent Ever in U. Armed Forces? 1 _Yes_2\ No tf Yes, Give Year or Dates:	1	Was Decedent of Hispa If Yes, specify Cuban, N 1 ☐ Yes 2 ☑ No S		cify Yes or No- Rican, etc.)	Black, Wi	nerican Indian, nite, etc. Black
N-6121:	within 72 hou iene. than "nature the Wedical E	Completed	15. Decedent's Edución (Specify only highest grade) Elementary/Secondary (0-12) 12th grade	ation completed) Cottege (1-4or 5+)	(Give	dent's Usuat Occupation kind of work done durin DO NOT use retired) CNA	n ng most of workii	ng	16b. Kind of Busines Nursing	,
	uld be filed Aental Hygi rked other tic event, I	To Be C	17. Father's Name (First, Middle, Last) Darrow T. Geter			18.	Mother's Name		Maiden Sumame) Car	
ž	ind 2 should talk and Meni 27 is marked		19a. Informant's Name/Relationship (Type Joyce M. Gardner		19b. Mailir 3721	ng Address <i>(Street and</i> Washingt	Number or Rura Con Ave	Balti	r, City or Town, State .more, Ma	zip Code) 21244 aryland
more,	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other 2002e.		20a. Method of Disposition 11 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)		emetery, crei	osition (Name of matory or other place) n Cemeter		2/05	20c. Location - City of Baltimon	orTown,Stete ce, Marylan
ранитог	Departit. Departit Importe eny inju		21. Signature of Funeral Service Licenza	~	5	2. Name and Address o 240 Reist	Facility Cha erstow	tman-H n Rd H	Harris Fu Baltimore	neral Home ,Md 21215
	hysician	ć	a. Part1 Enter the disease, or complic shock, or heart failure. List only one limediate Cause (Finat isease or condition resulting in death)	e cause on each line.				r respiratory ar	rest,	Approximate Intervat Between Onset and Death
	/Medical Examiner		Sequentially list conditions b.	Due to (or as a conseq	uence of):	Pneumon Heart Fo	inve			01/12/05
-	ate be executed nysician and he burial-transit	ical Examiner	if any, leading to immediate cause. Enter Indertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq						
n	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 শ No 9 ☐ Unknown	ic. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	ıl death 3 [□Ectopic pregnancy □ Other (specify)			23d. Date of o Month	elivery Day Year
ds, r.	requires that the een signed by th nould be detache	b	Part II. Other significant conditions cont	ributing to death but not res	sulting in the u	inderlying cause given ii	n Part I.			to the cause of death? Probably 4 Unknown
Hec	The larate has	Completed						1 ☐ Yes	rmed? prior t death 2 ∰ No 1 □ Y	autopsy findings available o completion of cause of ? as 2體No
OI VIE	SID	To Be	1 195 2 EF NO	ospital: 1 the patient 2		nt 3 DOA Other:		me 5 🗆 Resid	lence 6 Other (S)	pecify)
LOIS	tending Phieath. tor: After th	atlon:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work?	2 □ No	28d. Describe h	ow injury occurred	
DIVISION	To the Hospitel or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, sti	reet, factory, office		28f. Location (S City or Tow	Street and Number or m, State)	Rural Route Number,
	ne Hospi n 24 houn ne Funer. detely fill	Medical		ician: To the best of my kno er: On the basis of examina and manner stated.						
	To the vithin To the comp	W	29b. Signature and title of certifier	il.		29c. License nu			29d. Date signed (Mo	nth, Day, Year)
7	11/		30. Name and address of person who cor			Print) Union	Memor	ial Ho	spitul	11
6	/(/		Ali Esmuili 201 E	Registrar's Signa		my Bult	more,	MO 2	1218	
j.	Sta Regist	ate rar	FEB 0 9 2005	Blow H	Los	B				

		ļ	1 - For State Registrar	e of Maryland / D	Department of Health Certificate of Deat	and Mental Hy	•	03882
	Physici /Medic		Decedent's Name (First, Middle, Last) CATHERINE G	JTHRIE		2. Date of D Month	Day 2 Year	3. Time of Death
	Examir Funeral Director		4a. Facility Name (If not institution, give street at 5. Social Security Number 6. Sox 212–28–7068	7. Age (In yes. last birth	4b. City, Town, or Locatic Al Hoday) If Under 1 Year If Under 1 Year Days Hour	er 24 Hrs. 8. Date of Bi	ay, Year) Coi	hplace (State or Foreign untry)
	death with the Maryland rms 23e or 28e-f show rmust be notified at	tor	Usual Residence of Decedent 10a. State 10b. County MD N/A	10c. City, Town	or Location BALTIMORE			10d. Inside City Limits 1X Yes 2 □ No
	3e or 28	I Director	10e. Street and Number 5037 Wright Avenue		10f. Zip Code 2120	5	10g. Citizen of What Co.	•
036	be itled within 72 hours after death with the Marylan Hygiene. do thet than "neturel; or Items 23e or 28e-1 show event, Itte Marizal Examinat must be notified at	by Funeral	11. Marital Status 12. Was Arm 1 Never Married 2 Married 1 If Ye	Decedent Ever in U.S. d Forces? fes 2 XNo s, Give or Dates:	13. Was Decedent of Hispanic If Yes, specify Cuban, Mexic	Origin? (Specify Yes or No can, Puerto Rican, etc.)		ncan Indian, o, etc.
21215-0036	within 72 ho iene. r than "netur	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle	ted) 16a. 16a. 16a. 16a.	Decedent's Usual Occupation (Give kind of work done during m life. DO NOT use retired) STOCK CLERK	ost of working	16b. Kind of Business/I	
yiand	nould be filed I Mental Hygi narked other netic event, I	To Be C	17. Father's Name (First, Middle, Last) NICHOLAS GEORG		18. Mo BA		(WALTERS)	
, Mar	s 1 and 2 sho if Health and item 27 Is m other traum		19a. Informant's Name/Relationship (Type, Print MARGARET REYNOLDS/DAU	GHTER 1	Mailing Address (Street and Nun RAINTREE COURT		-	10
saitimore,	nit. Pages 1 and 2 should artment of Health and Men ortent: If item 27 is marke injury or other traumetic 8.		20a. Method of Disposition 1 ☐ Burial 2 (XCremation 3 ☐ Removal '4 ☐ Donation 5 ☐ Other (Specify)	rom State cemetery	Disposition (Name of r, crematory or other place) CREMATORY	Date 2-8-2005	20c. Location - City or 1	
gail	permit. Departrimporte eny inju		21. Signature of Funeral Service Licensee		22. Name and Address of Fac		EDALE FUNERA	L HOME
oo,	Physician /Medical Examiner	cal Examiner	Sequentially list conditions, b. ———————————————————————————————————	hat caused the death. Do not on each line. A + R / A / e to (or as a consequence of the to (or a)).	FIBRI,	as cardiac or respiratory a	rrest,	1237 Approximate Interval Between Onset and Death
. Box ba	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No. 4	s, outcome of pregnancy ive birth 2 Fetal death regnant at time of death Inknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliv	very Day Year
ecords, P	quires that in signed by uld be deta	by	Part II. Other significant conditions contributing	to death but not resulting in	the underlying cause given in Par		obacco use contribute to Yes 2 ☑ No 3 ☐ Pro	the cause of death?
al neco	Physicien: The law re r this certificate has bee iral director, page 2 sho	Completed	D M			24a. Was auto peric 1 \(\triangle Yes	psy prior to co ormed? death?	opsy findings available ompletion of cause of
DIVISION OF VITAL	ng the light	Certification; To Be	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 28e.	Inpatient 2 ER/Outp Date of Injury 28b. Tin Month, Day Year) Injury 28b. Tin Injury 28b. Tin Injury 28b. Tin Injury 38b. Tin I	patient 3 DOA Other: 4 me of ury M 1 Yes 2 [28d. Describe	dence 6 Other (Speci how injury occurred	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	(Check only 2 Medical Examiner: On I	o the best of my knowledge, he basis of examination and manner stated.	death occurred at the time, date of investigation, in my opinion, do	eath occurred at the time,	date and place, and due t	o the cause(s)
	with To COM	W	29b. Signature and title of certifier Wasia El-H	it ms	29c. License numbe	201	2 '7	2005
· ·	Sta	te	30. Name and address of person who completed WASSIM EI - H I I + I 31. Date filed Worth, Day, Year) FEB U 9 2005	cause of death (Item 23a) (T	Type, Print) Anklin Square	z Drie Ba	Ctimbre Pa	10 21237
	Registr	ar	1 20 0 0 2000					

05-00775 B.K.S VLADIMIR GROARK

DTM	IK GROP	илх	For State Registrar	State of	Maryland / Dep	artment o			lygiene Reg. No⊙ ∩	00	0000
	Q		1. Decedent's Name (First, Middle,	Last)				2. Date of	Death -	U 3 1 1/1	ime of Death
	Physici /Medi		Vladimir James	Groark				JAN.	29.20	05 17	00 P M
	Examir		4a. Facility Name (If not institution, PRINCE GEORGES			4b. City, Tow CHEVI	vn, or Location of ERLY		4c. Count	y of Death CE GEORG	
	Funeral Director		214-36-4986	6. Sex 7 1 DXM 2 ☐ F	. Age (In yrs. last birthday 65 Yrs.		ear If Under ays Hours		Birth Day, Year) 7 , 1939	9. Birthplace (S Country) Illino	State or Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				[40.1.1.	
	sho	ō	,	e Arundel		asadena					ide City Limits Yes 27 No
	28e-1	Director	10e. Street and Number	- Arunder					10 000		
	death with the Maryland ms 23e or 28e-f show finast be mutified at	Ö				10f. Zip Cod		0001		What Country?	
	ns 23	era	360 Riverside D		ent Ever in U.S. 13.	Was Decedent		-0291		ted State	
Maryland 21215-0036	hours after d	by Funeral	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 🛣 Divorced	Armed Ford	es?	If Yes, specify (_	gin? (Specify Yes or I, Puerto Rican, etc.)	Speci	ce - American Indi ick, White, etc. fy: White	an,
Õ	C1 62 10	Completed	15. Decedent's	s Education	16a. Dece	dent's Usual Oc	ccupation		16b. Kind of E	Jusiness/Industry	
215	be filed within 7 hal Hygiene. Ind othar than "in avant, It is Med	ed ((Specify only highest Elementary/Secondary (0-12)	College (1-4	life.	DO NOT use re	one during most stired)	t of working		,	
7	od wil	Son	12		,	Analys	t		Dei	ense Dep	t.
pu	al Hygie d othar i want, it	Be (17. Father's Name (First, Middle, L.	ast)			18. Mothe	r's Name (First, Midd	lle, Maiden Sumai	ne)	
<u> </u>	ould be Mental arkad c	2	Edgar Groark				Do	rothy Klee	espies		
ar.	s 1 and 2 should be f Health and Mental item 27 is markad othar traumatic av		19a. Informant's Name/Relationshi	р (Турө, Print)	19b. Mail	ng Address (Str	reet and Numbe	r or Rural Route Nun	ber, City or Town	, State, Zip Code)	
	D + C =		Fr. Paschal Mor	lino - Pr	rest	2 Wilker		Baltimor	e, MD.	21223	
ore.	of Her		20a. Method of Disposition 1 Disposition 2 Cremation	Bomoual from Ct	20b. Place of Dispo cemetery, cre	osition (Name of matory or other	f place)	Date	20c. Location	City or Town, Sta	ate
Ĕ	Pag nent ant: I		4 □ Ponation 5 □ Other (Spe		Bayview	Cremat	ory	2-9-05	Baltimo	ore, MD	
Baltimore,	permit. Pages 1 am Department of Healt Important: If item 2 any injury or other once.		1. Si malure) of Funda Service D	WDO				Ambrose Fring Rd.,			
			23a. Part1. Enter the disease, or c shock, or heart failure. List of	omplications that cau	ised the death. Do not en						ximate al Between
	Pnysician		Immediate Cause (Final disease or condition	Her	1 Livery	0 1	0.	1		Onset	and Death
	/Medical		resulting in death)	a Due to (or	as a consequence of):	ch L	ory to	elun			
	Examiner		Sequentially list conditions	h							
-	D #	ner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	Due to (or	as a consequence of):						
	cuter	Examiner	that initiated events	с.							
oʻ	e exe ian a irial-1	Ä	resulting in death) Last	Due to (or	as a consequence of):						
8760,	cate be executed physician and the burial-transit	dlcal		d							
39	ng ph ng ph as t	Med	IF FEMALE:				-				
.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		h 2 Fetal death 3 at at time of death 5	Ectopic pregna Other (specify				te of delivery Inth Day	Year
م:	that the ed by detacl		Part II. Other significant condition	s contributing to deal	th but not resulting in the u	nderlying cause	owen in Part I	23e Dio	tobacco use cont	ribute to the sauce	of dooth?
Records,	The law requires that the tite has been signed by thoage 2 should be detache	Completed by]Yes 2□No		4 Munknown
Sec	e taw has b je 2 st	nple						24a. Wa	ODSV	Were autopsy find prior to completion	ings available of cause of
		Ö.						per 1 🔁 Yes	formed? 2 ☐ No	death? X Yes 2□ No	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hereitel			_	of Death (Check only	one)	-	
of	di Si	ို	1 X Yes 2 No	Hospital: XXnp		IL JUDON		sing Home 5 Res			1
2	Attanding Pher death. ractor: After the by the funeral	on	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of (Month,	Injury 28b. Time of Day Year) Injury		njury at Work?	28d. Describe	how injury occur	ed Sulpet	cherry
Sic	Attanding r death. actor: After by the fune	cat	2 Accident investiga 3 ☐ Suicide 6 ☐ Could no	the Carlos		TILL	Yes 2 N		a acra	lu aceive	mt'
Division of	or At fiter of piracl	Certification:	4 Homicide determin	286. Place of	Injury - At home, farm, str , etc. (Specify)	eet, factory, office	Ce	28f. Location City or To	(Street and Numb own, State)	The second secon	Number,
	urs a				worker			Du	kek 110	land	
	To tha Hospitel or Attand within 24 hours after death To tha Funarel Diractor: completely filled in by the f	Medical	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the be aminer: On the basi and manner	est of my knowledge, deatl s of examination and/or in r stated.	n occurred at the vestigation, in m	e time, date and ny opinion, death	I place, and due to the n occurred at the time	e cause(s) and ma , date and place,	nner as stated. and due to the cau	ısə(s)
	To t To th	Σ	29b. Signature and title of certifier	. 10.			ense number		29d. Date signed	31, 2005	ar)
it.	261		1 / mle	Uller	4 may	0.	C.M.E		JAN.	DI, 2005	
10	yuy	1	30. Name and address of person wh	ng completed cause	STREET, 23aBALI	Priedon II	MDVT AND	21201			
6			THEODEREM, KIN	TIT ECUIN	OIREEI, DALI	APIORE, M	KATATATATA	, 21201			
	Sta	te	31. Date filed (Month, Day, Year)	2005 32. R	trar's Signature	gode					
	Registr	ar	LFR n S	2000							

		4	1 - For State of Maryland / Department of Health an Certificate of Death		giene Reg. No. 2005	03884
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) REGINA GROGAN	2. Date of De Month January	Day Year 26, 2005	3. Time of Death SOM M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of D	Death	4c. County of Death	
	•		3231 Strickland Street 5 Social Security Number 6 Sex 7 Age (In vrs. last birthday) If Under 1 Year If Under 24		N/A	Contract Contract
	Funeral Director			Hrs. 8. Date of Birt Min. (Month, Da Aug. 11	y, Year) 9. Birthp. Coun 1932 Mar	ace (State or Foreign try) 'Yland
			Usual Residence of Decedent	1.08. 1.		
	irylan ihow		10a. State 10b. County 10c. City, Town or Location		11	0d. Inside City Limits 1 Yes 2 No
	within 72 hours atter death with the Maryland ene. than "natural", or Itams 23a or 28a-f show Ita Mudeul Evar i art must be trofffed at	Funeral Director	MD N/A Baltimore		10.000	
	with ti	Ē	10e. Street and Number 10f. Zip Code		10g. Citizen of What Coun	,
	eath ns 23	era		? (Specify Yes or No	United S	
(0	r Itan	Fun	Armed Forces? If Yes, specify Cuban, Mexican, P 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒No	uerto Rican, etc.)		
9	ral', o	by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give 1 ☐ Yes 2 ☑ No Specify:		Specify: Whi	
21215-0036	72 h	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of	f working	16b. Kind of Business/Inc	lustry
121	within ane. than	dm	Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker		Own Home	
9	e filed within al Hygiene. othar than '			Name (First, Middle,		
lan	should be nd Mental marked o	To Be	John Joseph Barry Ann	na Watson		
Maryland	ds pu		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of	or Rural Route Number	er, City or Town, State, Zip	Code)
Σ	and 2 ealth a m 27 is		Mike Grogan Son 5525 Ore an Avenue,			
Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or othar t once.		20a. Method of Disposition 20b. Place of Disposition (Name of Morral Language) **Morral 2 Cremation 3 Removal from State Morral Language Morral La	Date	20c. Location - City or To	wn, State
Ħ	t. Pactiment:	1		the second secon	Lansdowne, M	
Bal	permil Depar Impol any ir	(21. Signature of Fune 1 3 77 10 10 10 10 10 10 10 10 10 10 10 10 10			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as car			Approximate
	Physician /Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. My rardal Infe 7 choresulting in death)	4		Interval Between Onset and Death
8760,	Examiner	cai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last My Tardal Infe I choronate of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	RM.		
O. Box 68	death certith e attending I ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delive Month	ry Day Year
α.	juires that the n signed by th ald be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to th	
Vital Records,	The law requires ate has been sign page 2 should be	Completed		24a. Was autor perfo 1 Yes		osy findings available inpletion of cause of
/ita	Physician: Th this certiticate ral director, pag	Be (examiner?	Death (Check only o	one)	
of \	Physi this o	۴	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursii		dence 6 Other (Specify how injury occurred	")
uc		tion	1 Natural 5 Pending (Month, Day Year) Injury Work?		now injury occurred	
Division of	atter death. I Diractor: Atte	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		Street and Number or Rura. wn, State)	Route Number,
	Hospita 4 hours Funaral	edical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and property of the pro	place, and due to the occurred at the time,	cause(s) and manner as st date and place, and due to	ated. the cause(s)
•	To tha within 2 To the complet	Me	(Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated. 29b. Signature and title of certifier 29c. License number 22c. License number 22c. License number 22c. License number 25c. License number 27c. Lice	6	29d. Date signed (Month, I	Day, Year)
	V		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BICH DUDNG, ND 724 MHIDEN CHOICE IN	1 BALT	IMIRE M.	2/228
	Sta Regist		31. Date filed (Month, Day, Year) 32. Recistrar's Signature (Month, Day, Year)			

				State of Maryland	/ Depa		t of H	ealth a		lental Hyg	iene	005	03885
	Dhysiei		1. Decedent's Name (First, Middle, Last)				_			2. Date of Deat	h	o o Xear	3. Time of Death
	Physici /Medic		FREDA		G	ANSLE				FEBRUAR	1		1405 PM
	Examin	ier	4a. Facility Name (If not institution, give st 725 MT. WILSON LA			4b. City,	lown, or	Location o	SVII	1 F	4c. Coul	nty of Death RA	LTIMORE
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under Months	1 Year Days	If Under 2		8. Date of Birth	Vearl		place (State or Foreign
	Director		130 10-2403	M 2 X F 92	Yrs.	MORIGIS	Days	riouis	IVIIII.	OCT. 17,	1912		VT
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation							10d. Inside City Limits
	a-fsh	ctor	MD BALTI	MORE	PIKE	SVILL	E						1 □Yes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip	Code	0100		1	0g. Citizen o	of What Cou	
	s 23a	eral	725 MT. WILSON LA	NE #406 2. Was Decedent Ever in U.S.	12.1	Was Deced	lent of His	2120		ocify Yes or No-	14 P	Race - Americ	USA can Indian
10	r Item	Fun	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give					, Puerto	ecify Yes or No- Rican, etc.)	В	lack, White,	etc.
93	ours a	d by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	21 X 1 No	Specify:			Spe	cify:	WHITE
15-(n 72 h "nett.	lete	15. Decedent's Educ (Specify only highest grade		16a. Deced (Give life.	dent's Usua kind of wor DO NOT us	k done d	urina most	of work	ing	16b. Kind of	Business/In	dustry
212	filed within 72 hours after death with the Maryland Hygiene. ther than "neturel" or Items 23a or 28a-f show out, the Mydical Esarili afternative notified at	Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4or 5+)	OWNE						RETAI	L SHOE	S
Maryland 21215-0036	be filed ital Hygi id other event, I	Be C	17. Father's Name (First, Middle, Last)							(First, Middle, M			
yla	should the marker than the mar	ဥ	ISADORE	on (Print)	MAND		/Stmat a	JI		al Route Number	GORDO City of Tou		a Cadal
	nd 2 sh lth and 27 is r		IRA GANSLER / SON			-				- BALTI			
re,	of Health item 27 other tr		20a. Method of Disposition	20b. Pla	ce of Dispo				-			n - City or To	
Ë	Pages ment of ant: If it ury or o		1 X Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Dopation 5 ☐ Other (Specify)	0HEB						5/2005	RE	ISTERS	STOWN, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23a or 28a-1 show amportant: or other traumatic event, Tre Medical Exertil entries to notified at Once.		21. Signature of uneral Service License	Muser	8	2. Name an 900 R	FIST	FRST(ו משכ	_ LEVINS ROAD - P	TKESV		INC. MD 21208
			23a. Part1. Enter the disease, or compile shock, or heart failure. List only one	eations that caused the death.	Do not ent	er the mod	e of dying	, such as	cardiac o	or respiratory arre	est,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	fancreat	ic c	canc							6 months
8	Examiner			Due to (or as a conseque	ence of):								
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events	Due to (or as a conseque	nce of):								
	be executed ician and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseque	anno of):								
760,		cal E		Due to (or as a conseque	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								
89	that the death certificate ed by the attending physi detached for use as the	ed	0.										
Вох	The taw requires that the death certifica the has been signed by the attending phoage 2 should be detached for use as it.	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome of pregnand 1 Live birth 2 Fetal of	death 3	Ectopic pr						Date of deliv Month	ery Day Year
O.	the al	ysicl	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4☐Pregnant at time of dea 9☐Unknown	ath 5□	Other (sp	ecify)						,
<u>α</u>	res that tigned by	by Ph	Part II. Other significant conditions con	tributing to death but not result	ting in the u	nderlying c	ause give	n in Part I.		23e. Did tob	oacco use co	ontribute to t	he cause of death?
rds	v requires been sig should be									1 🗆 Ye	s 2 No	3 🗌 Prol	bably 4 Unknown
Vital Records,	e taw re has be je 2 sho	Completed								24a. Was a autops	v l	prior to co	opsy findings available ompletion of cause of
a B										perform 1 ☐ Yes 2	2 23 0No	death?	2 🗆 No
Ζ	Physician: T this certificat ral director, pr	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ E	B/Outpatier	nt 3[] DC	Othe			me side		Other (Specia	fv)
J of		n: T	27. Manner of Death 1. Natural 5 Pending	Land Control of the C	28b. Time of		8c. Injury Work	at		28d. Describe ho			,
Siol	Attending r death. sctor: After	ertification;	2 Accident investigation 3 Suicide 6 Could not be			М		/es 2 □ I	No	204 Location /St	ront and Mu	=harar Bur	al Route Number,
Division	l or Attenuater deatl Director:	ertifi	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, iarm, str	eet, ractory	/, опісе			City or Town		IIIDƏI OI MUII	ai Adule ivaniber.
	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my know er: On the basis of examination and manner stated.	ledge, deat	h occurred vestigation	at the tim , in my op	e, date an pinion, dea	d place, th occurr	and due to the ca	ause(s) and ate and plac	manner as s	stated. o the cause(s)
	To the l within 2 To the I	Me	29b. Signature and title of certifier	Ma A		290	. License	number	LU	2	9d. Date sig	ned (Month,	Day, Year)
,	and I	-	1 DY oggen	(W)			U	278	77	J.	e bruo	ery O	4 2005
	00		30. Name and address of person who come to the second seco	00 Old Com	23a) (Type,	Print)	wite	2108	1	Pandall	stown	MO	
	Sta Registi		31. Date filed (Month, Day, Year) FEB	32. Registrar's Signatu 0 9 2005	ire	K,	her	W					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend item#19b per INF G840 2714 05 TT State of Maryland Department of Health and Mental Hygiene 20 Certificate of Death Reg. No. 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** John Harllee /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not institution, give street and number) Examiner Montgomery Bethesda Maple Wood If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 579 • 52 • 7507 7. Age (In yrs. last birthday) ff Under 1 Year 8. Date of Birth (Month, Day, Year)
Jan. 2,1914 6. Sex 1X M 2 ☐ F **Funeral** Days Months Hours Washington DC Director Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Health end Mentel Hygiene.

Int: If Item 27 is marked other than "natural; or items 23s or 28s-f show ary or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 No Director Bethesda MD Montgomery 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? United States 20814 9707 Old Georgetown Road Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1∑ Yes 2□ No If Yes, GiverWII/Korea Year or Dales: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 21 No Specify Specify: White ģ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) 4+ Elementery/Secondary (0-12) Rear Admiral Naval Officer U.S. Navy 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Ella Fulmore ဂ္ William C. Harllee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2069 Park RD N.W., Washington DC 20012 John W. M. Harllee/ GRANDSON 20010 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Department of important: If it any Injury or or 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/9/05 Alexandria, VA Mount Comfort Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility oseph Gawlers Sons, Inc. 5130 Wisconsin Ave. N.W., Washington DC 20016 M01378 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ,Pneumonia Examiner Due to (or es a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed inding physiclen and use es the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2X No 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient Medical Certification; To 1 Yes 2 No 2 ER/Outpatient 3□ DOA 27. Menner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 1 XNatural 2 Accident 5 Pending investigation s after death. 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1N Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State

Registrar

30. Name end address of person who completed ceuse of death (Item 23e) (Type, Print)

Ava Kaufman 31. Date filed (Month, Day, Year) FEB 0 9 2005

29b. Signature and title of certifier

Wisconsin Ave., Bethesda, MD 8218 2. Registrar's Signature

29c. License number

20814

D26259

29d. Date signed (Month, Dey, Year)

February 7, 2005

			1 - For Stata Registrar	State of Ma	arylan				lealth a Death	nd Me	ental Hy	giene	20	115	US	00-
			Decedent's Name (First, Middle, Last))							2. Date of De	aath		00	3. Time o	Death
	Physici		Alice		Α.			Har	ris	LIF.	Month ebruar	р Ба у 5,		Year 5	4:30	РМ
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)			4b. City,		r Location of		COLGGI		County			
4	L.Xaiiiii	CIA	4003 MARYLAND AVEN					1	BETHES	!DA			M	ONTO	OMERY	
	Funeral		5. Social Security Number 6. Sec	7. Ag		last birthday)	If Under		If Under 2 Hours	4 Hrs.	8. Date of Bir	th			lace (State	or Foreign
С	Director		578.62.4962]M 2\\ F	95	Yrs.	MOUNTS	Days	Hours	WIII.	(Month, Da August	26,1	909	Oph	elia,	Va
	pu ,		Usual Residence of Decedent 10a. State 10b. County		100 Cib	y, Town or Lo	antina							1	0d. Inside C	ibe Limita
	aryia shov	5	MD Montgo	merv		hesda	Cation							1		2 □ No
	he M	Director			1000	- Incode	10f. Zip	0-4	-			10- 08	izen of W	/h = 1 O = 1 =		
	with the sa or 3		10e. Street and Number													
	s 23	erai	4003 Maryland Ave.	12. Was Decedent	Ever in II	S 13		0816	ispanic Orio	in? (Spec	cify Yes or No		ed S		an Indian.	
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show ta Mudical Exama er inual ce toutified at	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces?			If Yes, spe	cify Cuba	in, Mexican,	Puerto F	Rican, etc.)	_		k, White,		
38	urs af	by	3 ℃ Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 🗋 Yes	2 X No	Specify:				Specify:	Whi	te	
Š	2 hou	ted	15. Decedent's Edu			16a. Dece						16b. K	ind of Bu	siness/Inc	dustry	
215	hin 7 a. an 'n Med	Completed	(Specify only highest grad	e <i>completed)</i> College (1-4or 5	5+)	life.	DO NOT u	se retired	during most d)	or workin	g					
21	filed withi Hygiene. othar than	ПО	12		,	Homam	aker	:				Owr	1 hom	ie		
b	al Hygid I othar vent, L	Be (17. Father's Name (First, Middle, Last)								(First, Middle			э)		
la	should be and Mental marked o	2	Andrew Jett Jones						Jessi	e re	e Will	lams				
Maryland 21215-0036			19a. Informant's Name/Relationship (T)	rpe, Print)		19b. Mailir	ng Address	(Street	and Number	r or Rural	Route Numb	er, City o	or Town, S	State, Zip	Code)	
	Health tam 27		Roger E. Harris /	SON	COL D				Ave.,							
OLE	ges 1 t of H if Ita or otl		20a. Method of Disposition 1 Burial 2 Coremation 3 DF	Removal from State	0	emetery, crei	natory or o	ne or other plac						•		
Ë	men tant: jury		* 4 □ Donation 5 □ Other (Specify)		Mt											
Baltimore,	permit. Pages 1 ar Department of Hea Important: if Itam any injury or otha onca.		21. Signature of Funeral Service Licens	athod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State												
	7 U = € 01		W 44/12	May									ngto	n DC		
н			23a. Part1. Enter the disease, or compl shock, or heart failure. List only of	ne cause of each li	ne.	n. Do not ent	er the mod	ie or ayın	ig, such as c	ardiac or	respiratory a	irrest,			Approximation on the Approximation of the Approxima	ween
	Physician		Immediate Cause (Final Isease or condition seulting in death) Hypertensive Heart Disease Due to (or as a consequence of):													
	/Medical Examiner			•		·								·		
М		5		Due to (or as												
/	nsit	ы Б	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Coronary	z Hea	rt Dis	ease							}		
,	sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as						-						
8760,	The law requires that the death certificate be exacuted ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai		d												
Φ	tificat ng phy as th	ledi														
Вох	leath certific attending pl	an/N	23b. was decedent pregnant	23c. If yes, outcome 1□Live birth			Ectopic p	reonancy	r				23d. Date		_	.,
-	ne deal the att hed fo	sicis	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 ☐ Pregnant at 9 ☐ Unknown			Other (sp						Mon	ith	Day	Year
P.0	that the ded by the detached	Physician/Me	9 Unknown								00 011					4
	res tha	by	Part II. Other significant conditions con Dementia	ntributing to death b	out not resi	uiting in the u	naeriying o	ause giv	en in Part I.				ise contri □No		e cause of o	Mnknown
orc	w requir been si should	ted	Demenera								,,,	103 2		0 1 102	abiy 4	
of Vital Records,	e law has b je 2 sl	Completed									24a. Was auto	psy	р	rior to coi	psy findings apletion of a	available ause of
H H	cate pag	Cor									1 ☐ Yes	ormed? 2 X No		eath?	2 No	
/ita	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	do noital:				0#		of Death	(Check only	оле)				
of	Physician: this certific ral director,	မ	T Tes 2X 140	dospital:		ER/Outpatier			4 🗀 1 4011		e Mariba				/)	
	ding f	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 3. Natural 5 Pending (Month, Day Year) 3. Natural 5 pending investigation (Month, Day Year) 3. Natural 5 results investigation (Month, Day Year) 4. Natural 5 results investigation (Month, Day Year) 4. Natural 5 results investigation (Month, Day Year) 4. Natural 5 results investigation (Month, Day Year) 4. Natural 5 results investigation (Month, Day Year) 4. Natural 5 results investigation (Month, Day Year) 4. Natural 5 results investigation (Month, Day Year) 4. Natural 5 results investigation (Month, Day Year) 4. Natural 5 results investigation (Month, Day Year) 4. Natural 5 results investigation (Month, Day Year) 4. Natural 5 results investigation (Month, Day Year) 4. Natural 6 results investigation (Month, Day Year) 4. Natural 6 results investigation (Month, Day Year) 4. Natural 6 results investigation (Month, Day Year) 4. Natural 6 results investigation (Month, Day Year) 4. Natural 6 results investigation (Month, Day Year) 4. Natural 6 results investigation (Month, Day Year) 4. Natural 7 results investigation (Month, Day Year) 4. Natural 7 results investigation (Month, Day Year) 4. Natural 7 results investigation (Month, Day Year) 4. Natural 8 results investigation (Month, Day Year) 4. Natural 8 results investigation (Month, Day Year) 4. Natural 8 results investigation (Month, Day Year) 4. Natural 8 results investigation (Month, Day Year) 4. Natural 8 results investigation (Month, Day Year) 4. Natural 8 results investigation (Month, Day Year) 4. Natural 8 results investigation (Month, Day Year) 4. Natural 8 results investigation (Month, Day Year) 4. Natural 8 results investigation (Month, Day Year) 4. Natural 8 results investigation (Month, Day Year) 4. Natural 8 results investigation (Month, Day Year) 4. Natural 8 results investigation (Month, Day Year) 4. Natural 8 results investigation (Month, Day Year) 4. Natural 8 results investigation (Month, Day Year) 4. Natural 8 results investigation (Month, Day Year) 4. Natural 8 results investigation (Mon									ry occurre	1 0				
isi	death.ctor: A	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inj	iury - At ho	ome farm str					8f. Location (Street ar	nd Numbe	r or Rura	I Route Nur	nher
Division	l or Attandater death Diractor:	Certification:	4 ☐ Homicide determined	building, et	c. (Specif	y) , iaiii, sti	cot, lactor	y, onice			City or To					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
			29a. Certifier t√ Certifying Phy	sicien: To the best	of my kno	wledge, deat	h occurred	at the tin	ne, date and	i place, a	nd due to the	cause(s) and mar	ner as st	ated.	
	To the Hospita within 24 hours To the Funaral completely filled	Medicai	29a. Certifier To Certifying Phy (Check only one) 2 Medical Exemi	ner: On the basis o and manner st	f examina ated.	tion and/or in	vestigation	, in my o	pinion, death	h occurre	d at the time,	date and	d place, a	nd due to	the cause(5)
	To th withir To th comp	Me	29b. Signature and title of certifier		2		29	c. Licens	e number			29d. Da	te signed	(Month,	Day, Year)	
	\sim	1) Juonn	0 U-()	0520	14		D473	330			Feb.	07,	200	5	
	10		30. Name and address of person who co	ompleted cause of o	ieath (Item	1 23а) (Туре,	Print)									
	`		Thomas V. Joseph /	50 W. Ed	lmons	ton Dr	., Ro	ockv:	ille,	MD	20852					
	Sta		31. Date filed (Month, Day, Year) FEB 0 9 20	32. Pigistr	ar's Signa	ture	1 "	_								
	Regist	ar	1 5 0 3 20	UJ ALES	de ,	B G	The said									

			1 - For State Registrar	State of Maryla		artment of I		•	giene	105	03000
	Physic	ian	1. Decedent's Name (First, Middle, Las.	•				2. Date of Dea	1000	Year	3. Time of Death
	/Medi	cal	Margaret C. Hop 4a. Facility Name (If not institution, give	*		4h City Tours	on Logotion of Dec	PEBRUA	44 3	2005	1050A M
	Exami	ier	Anne Arundel Medi			Annap	or Location of Dea	m		ty of Death Arur	
	Funeral	Г	5. Social Security Number 6. Se	7. Age (In yr	s. last birthday)	If Under 1 Year	If Under 24 Hrs				
	Director		173-18-6235 Usual Residence of Decedent	□M 2⊠F 84	Yrs.	Months Days	Hours Min	Dec. 26	1920	Penns	place (State or Foreign ntry) sylvania
	larylan show	2	10a. State 10b. County Maryland Anne An		City, Town or Lo Ferndal						10d. Inside City Limits
	the N	Director	10e. Street and Number	didei		10f. Zip Code			10g. Citizen of	LVAIIA Co.	1 ☐ Yes ¾Ã No
	h with		26 Vista Ave.			2106	1		United		•
	deat	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.			Specify Yes or No- to Rican, etc.)		ice - Ameri	can Indian,
39	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene, item 27 is marked other than "natural; or Items 23a or 28a-f show other traumatic event, the Medical Evaninar must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 □ Yes 2 🛣 No		to Hican, etc.)	Speci	ack, White, <i>ify:</i> Wh	etc. iite
Maryland 21215-0036	72 hou natura	Completed	15. Decedent's Edu (Specify only highest grad	ıcation	16a. Dece	dent's Usual Occup	pation		16b. Kind of E	Business/In	ndustry
2	within 72 ene. than "nai	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	during most of wo d)	rking			
2	e filed within al Hygiene. I other than ' vent, the Me		12 17. Father's Name (First, Middle, Last)		Accou	ntant Cl		- (First 16:44)			rnment
au	ould be i Mental I arked o	To Be	Clyde Hughes					me <i>(First, Middl</i> e, een Cleme		me)	
ary	12 should be and Mental hard Mental ramarked craumatic ev	-	19a. Informant's Name/Relationship (7)	rpe, Print)	19b. Mailir	g Address (Street	l	ıral Route Numbe		, State, Zip	Code)
	and 2 ealth a n 27 l		Mr. Jack Tishue, J		26 V	ista Ave	. Fernda:		21061		
Baltimore,	ges 1 It of H If iten	1	20a. Method of Disposition 1√2 Burial /2 □ Cremation 3 □ F	20b.	Place of Dispo cemetery, cren	sition (Name of natory or other pla	ce) Feb	Date ,	20c. Location	- City or To	own, State
弄	it. Pa intmen intant: njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fun ral Service (Licens			n Mem. P					Maryland
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra once.	19	DAN N CO	ave				neral Hom			
	*		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ication mat caused the de	ath. Do not ente	I Crain or the mode of dyir	Hwy . S.E. ng, such as cardia	• Glen Bu	irnie, est.		Approximate
	Physician	9	Immediate Cause (Final disease or condition	Sepsis						Mr.a.	Interval Between Onset and Death
	/Medical- Examiner		resulting in death)	Due to (or as a conse	equence of):						+ days
	- Xanninei	P.	Sequentially list conditions,	Due to (or as a conse	anence of:					_	
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Livesse of July that initiated events								
Ó	an an an irrial-tr	Еха	resulting in death) Last	Due to (or as a conse	equence of):						
8760,	cate be executed physician and the burial-transit	dicai		i							
9	leath certific attending p		IF FEMALE:	3c. If yes, outcome of pregr	nancy						
Bo	that the death cer ed by the attendin detached for use	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live birth 2 Fei 4 Pregnant at time of	tal death 3 🗆	Ectopic pregnancy Other (specify)	′			ite of delive onth	ory Day Year
P.O. Box	at the by the tacher	hys	9 □ Unknown	9□ Unknown							
S,	se un eq	by	Part II. Other significant conditions cor	~		derlying cause giv	en in Part I.	23e. Did tot	pacco use conf	tribute to th	ne cause of death?
Records,	w requir been si should	eted	Loton au	a with li	w me	TUTUS		1 □ Ye	s 2 ₩No	3 Prob	ably 4 Unknown
Rec	has b	Completed						24a. Was a autops perform	v	Were autor prior to con death?	psy findings available npletion of cause of
Vital		e Co	25. Was case referred to medical					1 ☐ Yes 2	P No		2 No
<u> </u>		0 B	examiner?	lospital: 1 Inpatient 2	☐ ER/Outpatient	3 DOA Oth		th <i>(Check only on</i> ome 5 ☐ Reside		or /Specif	a
0	ding Phys h. After this funeral di	T :uc	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	y at	28d. Describe ho	w injury occur	red	7
20	Attending ir death. ector: After by the funer	catio	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □ No				
Division of	of or Attency after death Director:	Certification:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, stre ify)	et, factory, office		28f. Location (Str City or Town	reet and Numb , State)	er or Rura	Route Number,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Phys	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the timestigation, in my of	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	iuse(s) and ma	anner as sta	ated. the cause(s)
	To the within Fo the comple	Med									
	7		1 Jent	- W.M.		2000	56650		Ester	,	2
	W		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type, F	Print)	0070		1001n	wy 3	NUS
			Titus Abraha.	a woi me	dical Pc	v Kwdy.	Arre Arus	del media	I Certer	An.	rapolis, MD 21401
*	Sta Registr		31. Date filed (Month, Day, Year)	mpleted cause of death (Ite Woi me 32. Registar's Sign	ature //	Sparker					

KG			State of Maryland / [Department of Health and M Certificate of Death	
	Physic /Medi Exami	2. Date of Death Month Day Year January 29, 2005 4c. County of Death			
	Funeral Director			Baltimore hday) H Under 1 Year If Under 24 Hrs. Months Days Hours Min.	NA 8. Date of Birth (Month, Day, Year) June 4, 1946 NA 9. Birthplace (State or Foreign Country) unk
	death with the Maryland ms 23e or 28e-f show	ector		orLocation Baltimore	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
		Funeral Director	10e. Street and Number 1016 W. Lanvale Street 11. Marital Status unk 12. Was Decedent Ever in U.S. Armed Forces?	10f. Zip Code 21217 13. Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto F	10g. Citizen of What Country? USA acify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.
21215-0036	n 72 hours after "neturel", or Ite	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 1 Yes 2 No If Yes, Give Year or Dates: 16. Decedent's Education (Specify only highest grade completed)	1 ☐ Yes 2 ☑ No Specify: Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)	Specify: other
	t be filed within ntal Hygiene. ed other then event, the M	Be Completed	Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Sumame) unk
e, Maryland	and 2 should ealth and Mei m 27 is mark her treumetic	70	O.C.M.E. 1	11 Penn Street Baltin	I Route Number, City or Town, State, Zip Code) more, MD 21201
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturenty injury or other treumetic event, the Medical Once.		1 □ Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 ☒ Other (Specify) in state	r, crematory or other place)	ate 20c. Location - City or Town, State
B	Dermi Depa Impo eny ii		21. Signature of Funeral Service Licensee Royald S Wade Director 23a. Part Enter the disease or complications that caused the death. Do no shock or heart failure. List only one cause on each line.		1655 W. Baltimore Street r respiratory arrest, Approximate Interval Between
8760,	Dhysician be executed by eath certificate be executed by eatherding physician and idea to transit as the british and for use as the british and the property of the property o	Ilcal Examiner	Immediate Cabse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence or Due to (or Due to):	
P.O. Box 6	at the death certifica by the attending phached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
	The law requires that the tee has been signed by thoage 2 should be detached.	by	Part II. Dther significant conditions contributing to death but not resulting in	he underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown
Vital Records,		e Completed	25. Was case referred to medical	26 Place of Death (24a. Was an autopsy findings available prior to completion of cause of death. 1 Yes 2 No 1 Yes 2 No
n of	ing Phys ifter this ineral di	Certification: To B	examiner? Name of Death Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)	ne of 28c. Injury at 28c	Bd. Describe how injury occurred
DİVİ	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to		3 Suicide 4 Homicide 28e. Place of Injury - At home, farm building, etc. (Specify) 29a. Certifier (Check only 2 Madical Exprisors Oct by home)		Bf. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Ho within 24 h To the Fu completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/and manner stated. 29b. Signature and title of certifier	or investigation, in my opinion, death occurred	d at the time, date and place, and due to the cause(s)
)	F 3 F 8		Maying Me Youll,	O.C.M.E.	29d. Date signed (Month, Day, Year) January 30, 2005
				pe.Print) 1 Penn Street, Baltin	
	Stat Registra	re.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Cools	

State of Maryland / Department of Health and Mental Hygiene o Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 27, **Physician** 2005 Harry B. Hall 6:00 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1247 Guilford Road Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. July 1, 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1⊠M 2□F 069-18-6012 82 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28e-f show the Medical Exeminer must be notified at MD Glen Burnie 1 Yes 2X No Funeral Director Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1247 Guilford Road Ітете 23a 21060 USA death 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White þ 42-46 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 is marked other It any injury or other traumatic svent, Ita once. supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry De Zee Cecclia Adalaide Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Hall/spouse 1247 Guilford Road Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21204 Ronald S. Wade 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician m disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Box 68760. cate has been signed by the attending physicien , page 2 should be detached for use as the buria Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 410 funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Certification: To 1 ☐ Yes 2 1 No 4 Nursing Home 5 Residence 2 ER/Outpatient 3 DOA 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 Yes 2 No within 24 hours after death. To the Funerel Director: A investigation 2 Accident the 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) filled in by 4 | Homicide Hospitei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the th 29b. Signature and title of certifier 29c. License number 29d. Date-signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a (Type, Print) Date liled (Month, Day, Year) legistrar's Signature State 0 9 2005 Registrar

	ın	1. Decedent's Name (First, Mid William F	Harrington						Date of Death Month	Day	Year Year	3. Time of Column 12:25p.
/Medic Examin		44. Facility Name (If not instituted to the second to the	er) Parkway	4b. City, Town, or Location of Death Rockville				4c. County of Death Montgomery				
uneral rector		5. Social Security Number 459–11–4548 Usual Residence of Decedent	6. Sex 1 M 2 □ F	Age (In yrs. last b	yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Date of Birth Month, Day, b.1, 2	Year) 2956	9. Birti Co Mor g	hplace (State or Fore untry) W VA gantown
a-f show		10a. State 10b. Cour	ntgomery	10c. City, To	wn or Lo							10d. Inside City Lim 1X Yes 2 □
or 28)irec	10e. Street and Number				10f. Zip Code			10	0g. Citizen	of What Co	untry?
itam 27 ia marked other than "naturel", or items 23a or 28a-f show other traumatic evant, the Modical Examiner must be notified at	by Fur	4717 Boiling 11. Marital Status 1 Never Married 2 XM 3 Widowed 4 Divorce	12. Was Deced Armed Forc 1 □ Yes 2 If Yes, Give Year or Dat	ent Ever in U.S. es? No es:	1		lispanic Orig an, Mexican Specify:	gin? (Specify , Puerto Rica	Yes or No- in, etc.)	Spe	Black, White	hite
other than "natu ant, I'm Musical	Completed	15. Deced (Specify only high Elementary/Secondary (0-12	dent's Education thest grade completed) College (1-4	(Give		dent's Usual Occupation kind of work done during most of working DO NOT use retired) Irance Agent				16b. Kind of Business/Industry Dental Insurance		
arked other	To Be Co	17. Father's Name (First, Middle William Sev		ton, SR.				rs Name (Fil		Maiden Sun	name)	
am 27 ia mai othar trauma		19a. Informant's Name/Relation Alexandra Apos				g Address (Street Boiling						
		20a. Method of Disposition 1 Burial 2 Ferematio 4 Donation 5 Other		tate cemei	of Dispo	sition (Name of natory or other place fort		Date D2/10/ 2			•	Town, State
Important: f any injury o once.		21. Signature of Funeral Servi	pp per DVR		22	. Name and Addre		OODC	ph Gaw	lers	Sons	
siciao :		Immediate Cause (Final	List only one cause on ea	ch line.		er the mode of dyir			spiratory arre	est,		
edical aminer transit	cal Examiner		a	Probable r as a consequence r as a consequence r as a consequence r as a consequence	ce of):				spiratory arre	est,		Interval Between
edical amd physician and see as the burial-transit	edicai Examin	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events	a	Probable r as a consequence r as a consequence r as a consequence ome of pregnancy th 2 Fetal dearn at time of death	e Car be of): be of): be of):		hythmi		spiratory arre		Date of del Month	Interval Betweer Onset and Deatl
gned by the attending physician and in a control of the policy of the print transit of the pr	by Physician/Medical Examin	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or mjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	a	Probable r as a consequence r as a consequence r as a consequence r as a consequence ome of pregnancy th 2 Fetal dea nt at time of death wn	e Car se of): se of): se of):	diac Arr	hy tha i	ia	23e. Did tob 1 □ Ye	23d. Dacco use o	Month contribute to	Interval Between Onset and Death Onset and Death Death Onset and Death Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death
ate has been signed by the attending physician and unit popage 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examin	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate gause. Enter Underlying Cause (Disease of mylly that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions.	a	Probable r as a consequence r as a consequence r as a consequence r as a consequence ome of pregnancy th 2 Fetal dea nt at time of death wn	e Car se of): se of): se of):	diac Arr	y ven in Part I.	ia	23e. Did tob 1 Yes 24a. Was as autops perform 1 Yes 2	23d. bacco use c as 2 XN in y med?	Month contribute to 3 Pr 4b. Were au prior to death?	livery Day Tobably 4 Unknowstein
ate has been signed by the attending physician and unit popage 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical Examin	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate gause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condessessions.	a	Probable r as a consequence r as a consequence r as a consequence ome of pregnancy th 2 Petal dea nt at time of death wn ath but not resulting	e Car pe of): pe of): ath 3[5[g in the u	Dectopic pregnance Other (specify)	y ven in Part I.	of Death (Co	23e. Did tot 1 Yes 24a. Was a utops perform 1 Yes 2 heck only on	23d. pacco use coas 2 XN in 2. in ad? XN No	Month contribute to 3 Pr 4b. Were at prior to death? 1 Yes	livery Day Year o the cause of death robably 4 Unknow utopsy findings avail completion of cause
In the this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit of the page 2 should be detached for use as the burial-transit of the page 2 should be detached for use as the burial-transit of the page 2 should be detached for use as the burial-transit of the page 2 should be detached for use as the burial-transit of the page 2 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use 3 should be	To Be Completed by Physician/Medical Examin	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Lisease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (o b. Due to (o c. Due to (o d. Due to (o d. Hospital: 1 India 28a. Date or (Month) 28a. Date or (Month)	Probable r as a consequence r as a consequence r as a consequence r as a consequence ome of pregnancy th 2 Fetal dea nt at time of death wn ath but not resulting	e Car se of): se of): se of):	DEctopic pregnance Other (specify) Inderlying cause given to 3 DOA Other Cause given to 3 DOA Other We wo	y ven in Part I. 26. Place	o of Death (Carsing Home	23e. Did tot 1 Yes 24a. Was a utops perform 1 Yes 2 heck only on	23d. pacco use coas 2 XN n 2: y mad? XN No	Month contribute to 3 Pr 4b. Were au prior to death? 1 Yes	livery Day Year o the cause of death robably 4 Unknow utopsy findings avail completion of cause
In the this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit of the page 2 should be detached for use as the burial-transit of the page 2 should be detached for use as the burial-transit of the page 2 should be detached for use as the burial-transit of the page 2 should be detached for use as the burial-transit of the page 2 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use 3 should be	To Be Completed by Physician/Medical Examin	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate gause. Enter Underlying Cause (Lisease of injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (o b. Due to (o c. Due to (o d. 23c. If yes, outce 1 Live bit 4 Pregna 9 Unknow ditions contributing to deal dical Hospital: 1 In In 28a. Date of (Month	Probable r as a consequence r as a consequence r as a consequence r as a consequence ome of pregnancy th 2 Fetal dea nt at time of death wn ath but not resulting	ce of): ce of): ce of): ce of): g in the u Coutpatier b. Time o	DEctopic pregnance Other (specify)	y ven in Part I. 26. Place her: 4 \(\text{Nu} \) Nu ry at rk?	o of Death (Coursing Home 28d.	23e. Did tot 1 Ye 24a. Was are autops perform 1 Yes 2 heck only on 5 Yeside Describe ho	23d. pacco use of as 2 \(\frac{N}{N} \) part and 2 22 \(\frac{N}{N} \) part and 8 \(\frac{N}{N} \) part injury oc	Month contribute to 3 Pr 4b. Were au prior to death? 1 Yes	livery Day Year o the cause of death robably 4 Unknow utopsy findings availacompletion of cause
In the this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit of the page 2 should be detached for use as the burial-transit of the page 2 should be detached for use as the burial-transit of the page 2 should be detached for use as the burial-transit of the page 2 should be detached for use as the burial-transit of the page 2 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use as the burial-transit of the page 3 should be detached for use 3 should be	edical Certification; To Be Completed by Physician/Medical Examin	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (o b. Due to (o c. Due to (o d	Probable r as a consequence r as	e Car ce of): ce of): dath 3[g in the u Outpatier b. Time o Injury , farm, str	Dectopic pregnance of the control of	y 26. Place her: 4 Nu ry at rk? Yes 2 I	o of Death (Coursing Home 28d.)	23e. Did tot 1 Yes 24a. Was an autops perform 1 Yes 2 heck only on 5 Yeside Describe ho Location (State of the cast the time, do	23d. pacco use of as 2 XN not	Month contribute to lo 3 Pr 4b. Were au prior to death? 1 Yes Courred dumber or Ri dumber as ace, and due	livery Onset and Death Day Year Day Year Day Hunking Day findings availated Completion of cause 2 No Decify) Day No Decify)
ther this certificate has been signed by the attending physician and inector, page 2 should be detached for use as the burial-transit in inector.	Certification: To Be Completed by Physician/Medical Examin	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or mijury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (o b. Due to (o c. Due to (o d	Probable r as a consequence r as	e Car ce of): ce of): dath 3[g in the u Outpatier b. Time o Injury , farm, str	DEctopic pregnance Other (specify)	y 26. Place her: 4 Nu ry at rk? Yes 2 I	o of Death (Coursing Home 28d.)	23e. Did tot 1 Ye 24a. Was are autops perform 1 Yes 2 heck only on 5 Ye side Describe ho Location (St City or Town due to the cat at the time, d	23d. bacco use of ass 2 XN n sy mad? XN No ance 6 Department and N. n, State) ause(s) and ate and pla	Month contribute to lo 3 Pr 4b. Were au prior to death? 1 Yes Courred dumber or Ri dumber as ace, and due	livery Day Year Day Year Dothe cause of death robably 4 Unknow utopsy findings availate completion of cause 2 No voify) ural Route Number, s stated. e to the cause(s)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 0306 3005 ames emuany /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner baltimere If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☑ M 2 □ F Yrs. Director 218-44-0901 58 Nov. 10,1946 Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or itama 23e or 28a-f show other traumatic avant, the Modical Examples I and the notified at 1 ☐ Yes 2 No Fullerton Directo Baltimore Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21236 <u>United States</u> 110 Leslie Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc. Amed Follow.

1X Yes 2 No
If Yes, Give
Year or Dates: 1966-72 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Assembler General Motors Corp. Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 9 James J. Hersl Edna M. Baker ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar Mrs. Mary L. Hersl/Wife 110 Leslie Ave. Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or once. ■Donation 5 ☐ Other (Specify) Hilltop Service Corp. 2/14/2005 Towson, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on any line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Monard /Medical Examiner orgestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) detached 1 ☐ Yes 2 ☐ No 9 Unknown þ cate has been signed in page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed certificate 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) To the Funaral Diractor: After th completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a To the Funaral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D. D005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karen Bld Hallaimen 3900 Lock 45nn 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 0 9 2005

ORIGINAL

		1 - For State Registrar			Departm		ealth and Mo Death	ental Hygie	-	05 03893
Physic		Decedent's Name (First, Middle, Last)	Glenn E	Elbert 1	Horton			2. Date of Death	Day	Year 3. Time of Death
/Med Exami		4a. Facility Name (If not institution, give s	treet and number,)	4b. (City, Town, or	Location of Death	COLVERY	4c. County of	D 10 .0 1
	М	Franklin Square Host 5. Social Security Number 6. Sex	oital Cen	ter ge (In yrs. last bir	7 7 7 7	SCORE 1 Year	If Under 24 Hrs.	8. Date of Birth	saitim	
Funeral Director			₂ M 2□ F /		Yrs. Mon		Hours Min.	(Month, Day, Ye May 17,1	ear)	Birthplace (State or Foreign Country) Virginia
pu 💃		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Limits
Manylan f show	5	Maryland Balt	more	100. Oky, 10W	II OI EGGATION		Midd	le River		1 ☐ Yes 2 XX
h the i	Director	10e. Street and Number		<u>.l</u>	10f	. Zip Code			Citizen of W	hat Country?
### 1215-0036 within 72 hours after death with the Maryland ane. "hetural; or Items 23s or 28e-1 show the Maryland Energheat neast be redified at		3302 Dahlia Lar					2122	J		States
ter dei	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	2. Was Decedent Armed Forces	?	13. Was D If Yes,	ecedent of His specify Cubar	spanic Origin? (Spec n, Mexican, Puerto P	cify Yes or No- lican, etc.)	14. Race Black	- American fndian, , White, etc.
036 Purs af	by F	3 Widowed 4 Divorced	t FeYes 2 ☐ If Yes, Give Year or Dates:	1942-46	1 🗆 Ye	s 2√ΩNo	Specify:		Specify:	White
215-0036 thin 72 hours aft e. an "netural; or Medical Erect	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a.	(Give kind o	Usuaf Occupa f work done d	luring most of workin	g 16b	, Kind of Bus	iness/Industry
within the same	Jumo	Elementary/Secondary (0-12)	Colfege (1-4or	5+)		Tuse retired;	Operator		Teamer	ters Union
ind 210 be filed wit tal Hygien d other th	Be Co	12 Years 17. Father's Name (First, Middle, Last)			TITLE	Truck	18. Mother's Name	(First, Middle, Maid		
2 B 2 5 5	To E	Elbert Hort	con					Pearlie	Cline	
Z sh and and ls m		19a. Informant's Name/Relationship (Type Geneva L. Horton	оө, Print) / Wii		-	ress <i>(Street a</i> ahlia	nd Number or Rural	<i>Route Number, Ci</i> dle River	-	itate, Zip Code) 21220
~) — E = N -		20a. Method of Disposition	/ WI	20b. Place of cemeter						City or Town, State
Baltimore, bennit. Pages 1 at Department of Hea mportent: If them any hojury or other pices.		1 ☑Burial 2 ☐ Cremation 3 ☐Ri 3 ☐ Other (Specify)	emoval from State	, ,			y 2/7/200	5	Baltin	more, Maryland
Baltimo Permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service License	е		22. Nam	e and Addres	s of Facility		ındalk	. Tnc.
m gaesa		Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Be interval Be						21222		
Frysician /Medical Examiner		Snock, or heart failure. List only on firmmediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Sephic	s a consequence		mode of dying	, such as cardiac of	respiratory arrest,		Approximate Interval Between Onset and Death
8760, ate be executed hysician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		s a consequence	•					
Division of Vital Records, P.O. Box 687(To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the t	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		e of pregnancy 2 □ Fetal death at time of death	3 □Ectop 5 □ Othe	ic pregnancy r (specify)			23d. Date Mont	of delivery th Day Year
Cords, F wrequires tha been signed should be del		Part II. Other significant conditions con	n the underlyi	ng cause give	n in Part I.	23e. Did tobacco use contribute to the cause 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4		oute to the cause of death? B Probably 4 Unknown		
Division of Vital Records, I or Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be continued.	Completed							24a. Was an autopsy performed	Dr	ere autopsy findings available for to completion of cause of ath? Yes 2 \bigsymbol{\text{\text{NO}}}
f Vital F vysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	ospital:			Otho	26. Place of Death	(Check only one)		
on of V ding Phys h. After this of funeral dir	lon: To	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of fni (Month, Da		Itpatient 3 Time of njury	DOA Othe	4 Nuising Hom	e 5 Residence		
Division To the Hospital or Attendir within 24 hours after death. To the Funerel Director: A	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	ijury - At home, fa tc. <i>(Specify)</i>				Bf. Location (Street City or Town, St		r or Rural Route Number,
e Hospita 124 hours Funerel	edical C	29a. Certifier 1 🔀 Certifying Phys (Check only one) 2 Medical Examin		of examination an						ner as stated. nd due to the cause(s)
To th within To th	Me	29b. Signature and title of certifier		100		29c. License	number	29d.	Date signed	(Month, Day, Year)
		Bonda	mon	ND		D6	1761	21	4/20	05
UT.		30. Name and address of person who co. Proscid N. Betadpu	r.H.D.	9000 Fm	(Type, Print)	Squar	e Drive 1	Baltimore	HD	21237
St Regist	ate trar	31. Date filod (Month, Day, Year) FEB 0 9 200	(A) 40.	rar's Signature		-				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 2335 M **Physician** Leona Lura Hendrix /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs.) Bel Air Harford 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 💆 F Days Hours Min. 68 218-32-7005 Director Sept.25, 1936 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1100 Shucks Road 21015 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ∐Yes 2√2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Vidowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction Owner / Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 Bledsue George Watson Ester Haley Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is rr any injury or other traum Elizabeth Hendrix - Daughter 1100 Shucks Road, Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gard. 2/10/2005 | Bel Air, Maryland 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home 1317 Cokesbury Road, Abingdon, Maryland 21000 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HNOX EWCEPHALOPATITY) 5 DAYS SPIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami EAST Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown rt I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical **Examiner**

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

TKndrix,

Physician/Medical þ Completed Be 2 Certification: in by

1 Yes 2 No 3 Probably 4 Unknown

Part II.	Other	significar	t conditions	s contributing	to death	but not	resulting i	n the	underlying	cause	given ir	ı Par

24a. Was an autopsy performed? 1 Yes 2 Nk

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?	Hospital:
1 Yes 2 No	Hospital: 1 Inpatient 2
27. Manner of Death 1. ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)

2 Accident

investigation

2 ER/Outpatient 3□ DOA 28b. Time of Injury 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	off

1 ☐ Yes 2 ☐ No Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
(Check only	2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the companion of th
one)	and manner stated.

29b.	Signature ar	nd title of certifier		
	1.00	tucia	aurn.	md

29c. License number

29d. Date signed (Month, Day, Year) FEBRUARY 6, ZOUS

Mucia ma and address of person who completed cause of death (Item 23a) (Type, Print)
TRICIA GURNY, MD UPPER CHESAPLAKE MEDICAL CENTER

BEL AIR MD

State Registrar

Medical

31. Date filed (Month, Day, Year)

9 2005

32. Registra de Signature

After

within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 1 ten 20 b per fth 3-4-05 vt 8841
State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 40 A M HARD -ARA EB 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth Month, Day, **Funeral** Days Hours Min Year) 8-28-889 1□M 20 F Yrs. Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Show ir then "neturel", or items 23a or 28e-f shov If e Medical Examiner must be natified at 1 Yes 2 □ No Director Mary and 10e. Street and Number MOC Of, Zip Code 10g. Citizen of What Country? death with 2122 842 more Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or item any injury or other treumatic event, it is Madical Extr. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ₩Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DQ NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) omema 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be P rene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1-t± Timore 20b. Place of Disposition (Name of 20a. Method of Disposition 2-22-05 20c. Location - City or Town, State emetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Cromatory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph L. Kuss tur 2222 W. North Ave. Homen esal tune 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pheral VASCULAR **Physician** Months /Medical Due to (or as a consequence of): Examiner Sequentially list to iditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 🗷 No Day 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by STAGE KEWAL DISTATE 1 Yes 2 No 3 Probably 4 Onknown Completed ementia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After t Certification: To the Hospitei or Attending 1. Natural Injury 5 Pending within 24 hours after death.

To the Funerel Director; All completely filled in by the fu 1 Tyes investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DACTIMONE MO 21202 10 301 PLACE JOSIPH PAUL (05TA

State Registrar 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year MILDRED JOHNSON **Physician** FEBRUARY 2300 M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPIMI NIA ST. AGNES BATIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** Hours Months 216.14.430 1 ☐ M 2 K F MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or 28a-f show BAUMORE 1 Nes 2 No Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number SARATOGA 3103 USA 238 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. is marked other than "neturel", or Ite 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) REPRESENTATIVE 12 TH GRADE AIN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MATTHEWS NICHOLAS JOHNSON LAURA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a-Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Dep riment of Health and Imp. ctant: If item 27 is m any injury or other traum once. DR. AYNOI PAGE 1EAGUE CATONSVILLE MD Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BALTO. MO KU00DLAKUN `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens CREMMION SERVICES 5151 BALTO. NATE PIKE, BALTO. MD 21229 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Pnysician ONE DAY /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unicated events initiated events resulting in death) Last Due to (or as a consequence of) use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 1 ☐ Yes Z No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐Other (Specify) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after destroy to the Funerel Directo completely filled in by the 3 🗌 Suicide determined 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P16693 FEBRUARY, 5, 2005 900 CATON BALTIMORE ATON AUTNUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 21229 HOSPITAL SARUMI AGNES

Registrar DHMH 17 Rev 1/200

State

10#5 595

Registrar's Signature

9 2005

9

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

•			For State Registrar	State of Maryland	Certificate of Death		
			Decedent's Name (First, Middle, Last	ot)	Totalio or Boali	Reg. N	3. Time of Death
	Physicia /Medic		ALICE	JACKSON		Febuary	4 2005 0300 M
	Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea	th 4	c. County of Death
			5. Social Security Number 6. S			S. I.P. Date of Birth	archine
	Funeral Director			□M 213/F 7.5	Yrs. Months Days Hours Min		9. Birthplace (State or Foreign Country) 3.2 MARYLING,
	ס		Usual Residence of Decedent				
	arylar show	ī	10a. State 10b. County		own or Location		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	ectc	MA. CarcL	ine	Denton	10.5	
	th with 23a or	Funeral Director		L Drive	21613	10g. C	Citizen of What Country?
	tams	unet	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Heatth and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23a or 28e-1 show or other traumatic avant, the Medical Evanimer must be rediffed at	Completed by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: BLack
5-	"natu	lete	15. Decedent's Ed (Specify only highest gra	lucation 1 de completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	orking 16b.	Kind of Business/Industry
12	within lene. than "	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemaker		Domestic
	illed Hygie other	a	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Maide	en Sumame)
/lar	Mental Mental Brkad c	To B	George Hoin	105	LULI	a Davis	
Maryland	2 sho and I is me	·	19a. Informant's Name/Relationship (19b. Mailing Address (Street and Number or F		
_	1 and Health em 27 ithar tr		th handa Cair 20a. Method of Disposition	1 Daughter	212 Mable Ave,		
Baltimore,	Pages nent of H int: If ite iry or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specific	I dilloval nom State	e of Disposition (Name of efery, crematory or other place)		Location City Hown, State ROLUNS VILLE, Md
alti	permit. Pag Department Important: I any injury c		21. Signature Tuneral Ferrice Licer		22. Name and Address of Facility	34 N. BR	vactury Barto
-	805 20		1 withing	precen	Miller's Metrope	elitan Cha	2 2 2
				plications that caused the death. I one cause on each line.	Do not enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death
層	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Illetasta	tic carcinoma o ce of): primary	Tunkno	wn I month
	Examiner			Due to (or as a consequen	ice of): primary		
		ner	Sequentially fat conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a consequen	ice of):		
	acuted ind transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C			
60,	tificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a consequen	ice of):		
68760,	rtificate og physi as the t	Aedicai		d			
Box (eath certif attending for use as	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delivery
B.	death e atte	Physician/	in the past 12 months?	1 Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deatl			Month Day Year
P.0	at the by th	hys	9 ☐ Unknown	9□ Unknown			
	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	by	Part II. Other significant conditions of	ontributing to death but not resulting	ng in the underlying cause given in Part I.		use contribute to the cause of death?
Records,	w requir been si should I	Completed				1 🗆 Yes	2 No 3 Probably 4 Unknown
3ec	The law cate has b page 2 sl	nple				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
a			25 14			performed?	death? 1 Yes 2 No
Vital		o Be	25. Was case referred to medical examiner? 1 \(\sum \) Yes \(\sum \) No	Hospital: 1 ☐ Inpatient 2 ☐ ER		ath (Check only one)	
of		-	27. Manuser of Death	CONTRACTOR OF THE PARTY OF THE	b. Time of 28c. Injury at	Home 5 Residence	
ion	Attanding r death. actor: After by the fune	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury Work? M 1 Yes 2 No		
Division	l or Attandi after death. Diractor: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	a, farm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
Ω	pital c		99				
	To the Hospital or Attanowithin 24 hours after death To the Funaral Director:	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	ysician: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death occurred at the time, date and place a and/or investigation, in my opinion, death occ	e, and due to the cause(urred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
	To the within To the Comp	×	29b. Signature and title of certifie	ma	29c. License number	29d. D	ate signed (Month, Day, Year)
)	^		· Cleb for	Well- mo	D35284	7 2	14/05
	9		30. Now and address of terson who	completed cause of death (Item 23	29c. License number D 35289 Sa) (Type, Print) S. Washingtonst	1=ctim	ma 7/1/1
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	B COUNTY OF STATE	wasjur (in upol
	Regist		FEB - 9 2005	Blacker St.	boods		
		001		100000	7		

VERNON C. JOHNSON State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Vernon Cleveland Johnson FEB 2005 1626 /Medical 4a. Facility Name (If not institution, give street and number) 7877 AMERICANA CIRCLE 4c. County of Death 4b. City, Town, or Location of Death Examiner GLEN BURNIE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 4, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 217 38 8445 6 Sex **Funeral** Days Min. Months Hours Maryland 1**X** M 2 ☐ F 63 Director Usual Residence of Decedent Manyland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic avant, I'm Medicul Exantrar mast be notified at 1 ☐ Yes 2 No Glen Burnie Maryland Anne Arundel Direct the 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code WITH 7877 Americana Circle Apt. 101 21061 U.S. Funerai death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene. Is marked other than "natural", or Itel 1979es 2□No IfYes, Give VietNam Year or Dates: VietNam 1 Never Married 2 Married Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sears 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Vernon C. Johnson, Sr. Rita Kalister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 s of Health an Item 27 is 5224 Benson Avenue Baltimore, Maryland 21227 Bonnie Beaver / step-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If It any injury or c 1 Burial 2 Cremation 3 Removal from State MD State Veteran Cem 2/8/2005 Crownsville, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee Baltimore, Maryland 21225 4001 Ritchie Highway 28a. Part1. Enter the disease, of shock, or heart failure. complications that caused the death. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory an Immediate Cause (Final disease or condition resulting in death) Physician len /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) _ the detached 9 Unknown 9 Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 24 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 \sum No 24a. Was an page 2 s autopsy performed? Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner?

1∑ Yes 2 □ No director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 \square Nursing Home 5 \square Residence XXOther (Specify)AT SCENE ပ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending investigation after death. М 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely To the within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Sign 2, 2005 O.C.M.E FEB. eath (Item 23a) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND 21201 31. Date filed (Month, Day, Year) State

Registrar

			1 - For State Registrar	State of Ma	ryland /		artment of I tificate of		nd Mental H	lygien Reg. N	200	5	03899
	Physici		Decedent's Name (First, Middle, Last	Annie Sue J	Iohnsor	,			2. Date of Month Februa	Death)ay	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give	e street and number)	Omisoi	1	4b. City, Town, o				c. County of		103
	Funeral Director		223 62 0421	C 14 007 F	(In yrs. last b 59	irthday) Yrs.	If Under 1 Year Months Days	If Under 2	Min. (Month,	Day, Yea	1945	Coun	ace (State or Foreign try) ginia
laryland	show a at	٥٢	Usual Residence of Decedent 10a. State 10b. County		10c. City, To						_	10	0d. Inside City Limits 1 X Yes 2 ☐ No
with the N	3a or 28a-f 4 be notifi	i Director	Maryland N/A 10e. Street and Number 1621 Popland St	reet	Bdl	timo	10f. Zip Code	26		10g. 0	Citizen of Wh	nat Coun	
:1215-0036 within 72 hours after death with the Maryland	al', or Itema 2 Examinar mui	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		1	Vas Decedent of I	lispanic Origi an, Mexican,	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race -	America White, 6	etc.
21215-0036 od within 72 hours aff	ne. han "natura e Medical E	Completed	15. Decedent's Ec (Specify only highest gra	l ducation ide completed) College (1-4or 5-		(Give life. L	lent's Usual Occup kind of work done DO NOT use retire	during most of	of working		Kind of Busi		ustry
land 21	fental Hygier rked other ti lic event, In	To Be Cor	6th 17. Father's Name (First, Middle, Last) (Not Available)			W	orker		s Name (First, Mid	dle, Maide			
, Maryland	ealth and M n 27 is mar ser traumat		19a. Informant's Name/Relationship (Robert Riffey /		1	621	Popland	Street		imore	, Mar	ylan	d 21226
Baltimore,	Department of Health and Mental Hygiene. Important: or itema 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at 2006.		20a. Method of Disposition 1 \(\begin{align*} \text{Surial} & 2 \text{Cremation} & 3 \text{4} \text{Donation} & 5 \text{Other} \((Specifination \text{21}) \). Signature of Funeral Service Licer	y)	1	Have	sition (Name of natory or other place) natory or other place n Mem. I Name and Addre	Park 2	Gonce F	Gle unera	al Ser	nie, vice	Maryland, P.A.
Pi / E	nysician /Medical xaminer	niner	23a. Part1. Enter the disease, or consolock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Due to (or as a	consequence	o not enter	150250				more,	3	rland 21225 Approximate Interval Between Onset and Death Iday
Records, P.O. Box 68760,\ The law requires that the death certificate be executed		Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as a d. 23c. If yes, outcome of the pregnant at the second of the pregnant at the purchase of the pregnant at the purchase of the pregnant at th	onsequence of pregnancy	a of):	Ectopic pregnance	4			23d. Date (of deliver	
Records, P.	been signed by the s should be detached t	b	Part II. Other significant conditions o	ontributing to death bu	t not resulting	in the ur	iderlying cause giv	en in Part I.	1	Yes :	_		e cause of death?
		e Completed	25. Was case referred to medical					26 Place o	24a. W au pe 1 Yes	itopsy informed? s 2 5 N	pridea	or to com ath?	sy findings available ipletion of cause of
of Vita Physiclan:	this certific al director,	ToB	examiner? 1 ☐ Yes 2 © No	Hospital: 1 - Inpatier		- 12		er: 4 🗆 Nurs	ing Home 5□R		6 □Other	(Specify)	
Division (leath. tor: After the fune	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		Year)	Time of Injury					ury occurred		
Divi	ours after deat eral Director: filled in by the		4 Homicide determined	building, etc.	(Specily)				City or	Town, Sta	te)		Route Number,
o the Hos	within 24 hours after of To the Funeral Direct completely filled in by	Medical		ysician: To the best on niner: On the basis of and manner stat	examination a	nd/or inv	restigation, in my o	pinion, death	occurred at the tim	e, date a	s) and mann nd place, and ate signed (i	d due to	the cause(s)
	3		30. Name and address of person who	mD completed cause of de	ath (Item 23a)	(Type I	/	3894	6	Febil	var o	5 2	1.005
	Sta	ate	STUDST Shindle In Ze 31. Date filed (Month, Day, Year)	0/ F. Unil 32. Registra	(CS TY)			alTimo	2 177	21.	218	·	
DHMH	Registi 1 17 Rev 1/2		FEB 0	9 2005		B	Sports			<u>. </u>			
					ORI	GINA	L						

		1 - For State Registrar	State of Maryland / De	partment of Health and Pertificate of Death	Mental Hygier	•	0390
Physic /Medi Exami	ical	Decedent's Name (First, Middle, Last James Z. 4a. Facility Name (If not institution, give 1299 Montclair I	Johnson street and number)	4b. City, Town, or Location of Deat	February	Oay Year 04 2005 4c. County of Deat Anne Ay	
Funeral Director		5. Social Security Number 6. S		ay) If Under 1 Year If Under 24 Hrs		9 Birt	thplace (State or Foreig buntry) VA
within 72 hours after death with the Maryland sne. sne. than "natural", or items 23s or 28s-f show he Medical Examination in the solid at	ector	10a. State 10b. County Maryland Anne /	10c. City, Town o	Pasadena	100	Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
s 23a or	Funeral Director	1299 Montclair [21122		USA	
ours after de ai', or items	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Anned Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer Yes 2∑ No Specify: 	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) (G College (1-4or 5+)	ecedent's Usual Occupation live kind of work done during most of wo e. DO NOT use retired) DUSE Of Correction	rking	Kind of Business	·
Mai yiaina 4.14.1.5-0000 nd 2 should be filed within 72 hours at the and Mental Hygiene. 27 is marked other than "natural", or rtraumatic event, the Medical Ensure	To Be Co	17. Father's Name (First, Middle, Last) Harry Jol	nnson		me (First, Middle, Maid	len Sumame)	oca ce
and 2 sho and 2 sho ealth and ! m 27 is ma	ľ	19a. Informant's Name/Relationship (Shannon Hairsine		ailing Address <i>(Street and N</i> um <i>ber or R</i> o ? Freedom Avenue, N			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Deprint. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Depriment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at any injury or other traumatic event, the Medical Examinat must be notified at		20a. Method of Disposition 1 Surial 2 Cremation 3 C 4 Donation 5 Other (Specification of the control of the c	Meadowr	sposition (Name of crematory or other place) ridge Cemetery 22. Name and Address of Facility 3111 Mountain Roa	005 El Stallings	kridge, M Funeral	Maryland Home, P.A.
Physician /Medical		23a, Part1. Enter the dishuse, or com shock, or heart failurs. List only Immediate Cause (Final disease or condition resulting in death)	blicators that caused the death. Do not one cause in each line. a. Cerebrovascular Due to (or as a consequence of):	enter the mode of dying, such as cardian Accident		u, 110 21	Approximate Interval Between Onset and Death
ate be executed Thysician and The burial-transit	Icai Examiner	Sequentially list conditions, "any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Right Caratid (Due to (or as a consequence of): c. Chronic Arteria Due to (or as a consequence of): d.				4 years 4 years
ath certific	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 9□Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of deli Month	ivery Day Year
quires that the de n signed by the a	þ	Part II. Other significant conditions of	ontributing to death but not resulting in th	e underlying cause given in Part I.			the cause of death?
To the Hospital or Attending Physician: The law requires the Within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be completely filled in by the funeral director.	Completed				24a. Was an autopsy performed 1 Yes 2 💢	prior to o death?	itopsy findings available completion of cause of 2∑ No
raician s certifii director	To Be	25. Was case referred to medical examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa		ath (Check only one) lome 5 X Residence	6 DOthor (Spa	olf d
or Attending Physician: 1 after death. Director: After this certificat	Certification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b. Tim Inju	e of 28c. Injury at Work? M 1 Tyes 2 No	28d. Describe how in	jury occurred	
vital or At urs after d rai Direct		4 Homicide determined	building, etc. (Specify)		28f. Location (Street City or Town, Sta	ate)	
To the Hospital Within 24 hours a To the Funeral I	ledical	(Check only 2 Medical Examone)	ysician: To the best of my knowledge, d hiner: On the basis of examination and of and manner stated.	investigation, in my opinion, death occu	irred at the time, date a	and place, and due	to the cause(s)
2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	×	29b Signature and title of certifier		29c. License number D18508		Date signed <i>(Montl</i> bruary 7,	•
10/1	-		completed cause of death (Item 23a) (Ty	pe, Print			, 2003
Si Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	A. a	CITIC, ND	<u> </u>	

				1- For State of Maryland / Department of Health and Monage Certificate of Death	ental Hygier	2005 0000
		Physici /Medi		LLCYD D. JACKSON	2. Date of Death Month February	Day Year 3. Time of Death
		Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death
		Funeral Director		215-68-4889 IX M 2 F 48 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	Harford 9. Birthplace (State or Foreign Country) 956 Maryland
0		and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	1	10d. Inside City Limits
Ø		death with the Maryland me 23e or 28e-f show	ţo	Maryland Harford Belcamp		1 ☐ Yes 2 No
R		or 28	Funeral Director	10e. Street and Number 10f. Zip Code	10g. (Citizen of What Country?
		eath w	eral	4309 Pulaski Hwy., PO Box 12 21017 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	nifu Voe or No	USA 14. Race - American Indian,
10	9	efter d or Item ultrier		Armed Forces? If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White, etc.
100	003	urel',	d by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:		Specify: White
32/04/05	Maryland 21215-0036	2 should be filed within 72 hours efter death w and Mental Hygiene. Is marked other then "neturel", or fleme 23e eumatic event, the Mydical Examination until	Completed	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of workin life. DO NOT use retired)	g 16b.	Kind of Business/Industry
7	212	ad with	Com	Elementary/Secondary (0-12) College (1-4or 5+) 11 Press Operator	Rub	ber Manufacturing
0	and	I be filk	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name		· ·
	Ž	should nd Mei mark matic	10	Charles James Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural		h Spurlin
~^		1 and 2. Health ar tem 27 is		Linda D. Ledbetter - Sister 2924 Ruskin Ct., Abing		
9	Baltimore,	permit Pages 1 and 2 should be filed within 72 hours efter death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturef", or Iteme 23e or 28e-f show any injury or other treumatic event, the Midical Externition was be profifted at 00.8e.	T	20a. Method of Disposition 1 ☐ Burial 2 ☑ ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	ate 20c.	Location - City or Town, State
3	튶	urmen brient: njury		*4 □ Donation 5 □ Other (Specify) Hilltop Services 2-9-0 21. Signature of Funeral/Service Ligenses 22. Name and Address of Facility	5 Tow	son, Maryland
7	Ва	permit Depar Import any in		McComas Funeral Home	9	- W 7 7 7 01000
\odot		(A) (基)		23a. Part1. Enter the disease, or complicators that austral the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only on suse each line.	respiratory arrest,	Approximate Interval Between
-		Physician		Immediate Cause (Final disease or condition resulting in death) a. OPPORTUNISTIC PNEUMONIA		Onset and Death 5 weeks
A C		/Medical Examiner		Due to (or as a consequence of): $A \perp D \leq$		
\leq		7 F	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
		ate be executed hysicien and the burial-transit	Examiner	rnat initiated events c.		
2	8760,	sicien burial		Due to (or as a consequence of):		
0	687	certificate I nding physi- use as the b	fedic	g.		
77 17	Ó. Box	death e atte	hysiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
SON	rds, P	Se un e	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ALCOHOLISM	23e. Did tobacco	o use contribute to the cause of death? 2 No 3 Frobably 4 Unknown
X	eco	aw as b	Completed	VIRAL HEPATITIS	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
A	E R	The ate h page	Com		performed? 1 ☐ Yes 2 ☐ 1	death?
	Vital	Physicien: Th this certificate ral director, pag	Be c	25. Was case referred to medical examiner? 1 Yes 2 No		
	10		on: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28	e 5 ☐ Residence 3d. Describe how inj	
	sior	ttendin death. ctor: Aft / the fun	atlo	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No		
	Division	ire (d c	Certificat	4 Homicide determined 286. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify)	City or Town, Sta	
		To the Hospitel of within 24 hours of To the Funerel D completely filled in	edical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause(d at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
		To th within To th comp	Me	29b. Signature and title of certifier 29c. License number 29c. License number		Date signed (Month, Day, Year)
		1	2	D 21207	FE	BRUARY STH 2005
	5	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANZ C. VELLA-CAMILLERI M.D. 5 MIDCREST COORT	BALTIMO	DRE MD 21286
		Sta Registr	0 10	31. Date filed (Month, Day, Year) 7 2005 Registrate Signature 1. Specific States 1. Speci		

				State of Maryland					•	DIE.	
			1 - For State Registrar			tificate of De			g. No.	15	03902
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Deat		Year	3. Time of Death
	/Medic		Elaine B.	Kotmair				February		005	9:30 PM
	Examir	ner	4a. Facility Name (If not institution, give s Mariner Health of			4b. City, Town, or Lo	Burnie		4c. County		^undel
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia		If Under 1 Year II	f Under 24 Hrs.	8. Date of Birth	1		place (State or Foreign
	Director		219-10-3001	M 21√2 F 8'	Yrs.	Months Days	Hours Min.	8. Date of Birth June U	1923		MD MD
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				Ţ,	IOd. Inside City Limits
	Mary a-f eh	tor	Maryland Anne Ar	undel		Pasad	dena				1 ☐ Yes 2 🖾 No
	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V		ntry?
	s 23a	rall	2906 Golden Fleec		2 40.1		21122	7		ISA	and the state of
"	fter de r ttem Irer r	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	 Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No 	5. 13. 1	Vas Decedent of Hispa f Yes, specify Cuban, I	anic Origin? (Spe Mexican, Puerto	ecity Yes or No- Rican, etc.)		k, White,	
936	ral', o	1 by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		I□Yes 2XINo S	Specify:		Specify	· h	Mhite
5-0	"natu	letec	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	lent's Usual Occupation kind of work done duri DO NOT use retired)	on ing most of work	ing	16b. Kind of Bu	siness/In	dustry
12	withir lene. than	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	me. i	Secretary			Motor '	/ehi	cle Admin.
DG 2	be filed stal Hygi od other event, I	Be C	17. Father's Name (First, Middle, Last)			18		e (First, Middle, M	Maiden Sumam		
ylar	should be and Mental I marked or umatic eve	ToE		leiter			Bessi		rtman		
Maryland 21215-0036	12 sho h and 7 is ma traum		19a. Informant's Name/Relation \$\frac{4}{3} ip (Type Kim Starr (dau			g Address (Street and					
	Health tem 27 other tr		20a. Method of Disposition	ghter)	ace of Dispo) Wiltshire sition (Name of natory or other place)		Date	10 MD 2		
m _o	Pages ient of nt: tf li ry or c		1 🖾 Burial 2 □ Cremation 3 □ Re `4 □ Donation 5 □ Other (Specify)	emoval from State Ball	imetery, cren timore	National (Cem Feb.	09	Baltimo	re, I	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at Once.		21. Signature of Funeral Service License	·la)	22	. Name and Address of					Home, P.A.
8	20599	0.00	phyd de			3111 Mou	ntain Ro	oad. Pasa	adena.	VID 2	1122
			23a. Part. Enter the deease, or complic shock, or heart fair tre. List only on Immediate Cause (Final	e laust on each line.	. Do not ent	er the mode of dying, s	such as cardiac o	or respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ	ience of).	my 1000	my wo	Juse		-	years
Н	Examiner		Sequentially list conditions b			0	•				
- 24	pe sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ence of):						
	xecut and	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):						
760,	ate be executed sysician and he burial-transit	calE	d								
68	The law requires that the death certificat ate has been signed by the attending phycage 2 should be detached for use as the		IF FEMALE:							1	
Вох	ath ce attend for use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	Ic. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date Mor		ery Day Year
o.	that the de ed by the detached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	aui ol	Other (specify)					
ď,	es that igned b	by PI	Part II. Other significant conditions con		lting in the ur	nderlying cause given i	in Part I.	23e. Did tob	acco use contr	bute to ti	ne cause of death?
ord	w require been sig	ted	Dighetti me	hi hus				1 □ Ye	s 2 No	3 Prob	pably 4 Unknown
Records,	has b	Completed	Hyperturion	~				24a. Was ar autops perforn	v p		psy findings available mpletion of cause of
Vital F		e Col	OS Was seen referred to medical					1 ☐ Yes 2	No 1	Yes	2 □ No
Ξ	> 00	0 8	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 E	ER/Outpatien			n <i>(Check only one</i> me 5 ☐ Reside		r (Specif	v)
n of		on: T	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		28d. Describe ho			,,
Division	Vttendir death. ctor: Al y the fu	cath	2 Accident investigation 3 Suicide 6 Could not be	20 01: (1: 415			s 2 No	201 1 /24			
Div	or Attendate death Director:	Certification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, rarm, str	eet, ractory, office		28f. Location (Sti City or Town		ir or Hurz	ii Houte Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C	(Check only 5 Medical Examin	ician: To the best of my know er: On the basis of examinati and manner stated.	ion and/or inv	estination in my onini	ion, death occurr	ed at the time da	te and place, a	nd due to	the cause(s)
	vithin somple	Med	29b. Signature and title of certifier	and mariner stated.		29c. License nu	umber	25	d. Date signed	(Month,	Day, Year)
/	1		> /BOUNA)		D-4	0521	1	elsono	my 7	,2005
1	716	15	30. Name and address of pers to who con	npleted cause of death (Item	23a) (Type,	Print) 325 t	HOSPITO	el Driv	e Sui	Fe .	205
1	(DK. OCHANEJ 31. Date filed (Month, Day, Year)	32, Raistrar's Signat	ure	See Ste	n Bu	rnie, N	D 516	120	
2	Sta Registi		FEB 0 9 20	and manner stated. pleted cause of death (Item 32. Registrar's Signat	J. A	PARE					

			1- For State of Maryland / Department Certificate		Mental Hygie	2000	03903
	0		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Gilbert A. King		February	5 2005	7103 PM
1	Examin	er		own, or Location of Death		4c. County of Death	
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	(timore Year If Under 24 Hrs.	City	N/A	Jana (State or Foreign
П	Funeral Director			Days Hours Min.	8. Date of Birth (Month, Day, Ye Sept. 08	1955	place (State or Foreign htry)
	ס		Usual Residence of Decedent		100pu. 00		
	anylar show	'n	10a. State 10b. County 10c. City, Town or Location	Baltimore		1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the M	Director	10f. Zip C		100	Citizen of What Coun	
	3a or		1341 E Patapsco Avenue	21225	,	USA	uy:
	death	Funeral		nt of Hispanic Origin? (S y Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Americ	
920	be filed within 72 hours after death with the Maryland nat Hygiene. od other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be motified at	by Fu	Armed Forces? If Yes, specification of the following specific		o Rican, etc.)	Specify: White,	
2 - 0	72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual (Specify only highest grade completed) (Give kind of work	Occupation done during most of wor	rkina 16b	. Kind of Business/Ind	dustry
2	han "	mple	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use	retired)	9	D: 1	
7	e filed within al Hygiene. other than '		b MeC	hanic	ne (First, Middle, Maid	Diesel	
and	d be feed of c	To Be	James W. King	Joseph		Herd	
ary	2 should be and Mental Is marked of raumatic ev	۲		Street and Number or Ru		ty or Town, State, Zip	Code)
Σ	and 2 salth a n 27 is			te Drive, G	len Burnie	, MD 21060	
lore	ges 1 and 2 should it of Health and Mer if Item 27 is marke or other traumatic		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name cemetery, crematory or oth	er place) Feb	. 10	. Location - City or To	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra		'4 □Donation 5 □Other (Specify) Glen Haven Ceme 21. Signature of Foreign Service (Consee 22. Name and	etery 2(Address of Facility		en Burnie, Funeral H	
8	89 1 8 8		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode	ountain Roa	<u>d, Pasaden</u>	a, MD 2112	Approximate
	(Boundales		Immediate Cause (Final	or dying, such as cardiac	or respiratory arrest,		Interval Between Onset and Death
	Pnysician /Medical Examiner		disease or condition resulting in death) Due to (only a consequence of):	ection			
	Examiner	<u></u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	20			
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate sauds. Litter Underlying Cause (Disease or injury that initiated events				
Ö,	cale be executed physician and the burial-transit	i Exa	resulting in death) Last Due to (or as a consequence of):				
8760,	cate be ex physician the buria	dicai	d				
9 X	eath certifii attending p for use as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	in/
Вох	atte	Physician/Me	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic preciation to the past 12 months? 4 Pregnant at time of death 5 Other (special preciation)				Day Year
P.0	that the de ed by the detached	hys	9 ☐ Unknown				
	es ign	by	Part II. Dther significant conditions contributing to death but not resulting in the underlying cau	use given in Part I.	23e. Did tobacc	co use contribute to th	
orc	w requii been s should	eted					
Records,	The taw ate has b page 2 s	Completed			24a. Was an autopsy performed	prior to con death?	psy findings available inpletion of cause of
Vital		e Cc	25. Was case referred to medical	26 Place of Dea	1 ☐ Yes 2 ≥ ath (Check only one)	No 1 ☐ Yes	2 No
<u> </u>	9 G :=	OB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA		lome 5 Residence	6 ☐Other (Specify	()
n of		on: T	27. Manner of Death 1 ▼Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c.	c. Injury at Work?	28d. Describe how in		
Sio	Attending r death. ector: After by the fune	catio	2 Accident investigation M	1 ☐ Yes 2 ☐ No			
Division	al or Attend s after death il Director; / id in by the f	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	office	City or Town, St	t and Number or Rura tate)	Houte Number,
	To the Hospital or At within 24 hours after o To the Funeral Direc completely filled in by	Medical C	29a. Certifier (Check only one) **Certifying Physicien: To the best of my knowledge, death occurred at 2 Medicel Examiner: On the basis of examination and/or investigation, in and manner stated.	the time, date and place n my opinion, death occu	and due to the cause rred at the time, date	e(s) and manner as standard place, and due to	ated. the cause(s)
	within 2 To the complet	Me	29b. Signature and title of certifier 29c.	License number		Date signed (Month, L	
0	10)	Ali Ban, M.D.	RES-00	O Fe	boung &	5,2005
6	571		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) All' Baa (MD Sinai Mosspital)	RES-00	Baltim	or e	
	Sta		31. Date filed (Month, Day, Year) FEB 0 9 2005 Sleen & Joseph Land	,	, , ,		
	Registr	ar .	The state of free to free to	/			

1000		ľ	For State Registrar	State of N	Maryland / De	epartm		ealth a				005	03901
/M	sicia ledic	al	1. Decedent's Name (First, Middle, La TIMOTHY	KLE]						2. Date of Dea Month FEBRUAR	RY 4	200°5	3. Time of Death 8:05a M
	amine		4a. Facility Name (If not institution, giv 7907 OAKDALE AV 5. Social Security Number 6. S	/ENUE		RC	ity, Town, or SEDALE der 1 Year				BAI	unty of Death	
Fune Direc				M 2□F	Age (In yrs. last birth) 81 _{Yr}	Mont		Hours	Min.	8. Date of Birth (Month, Day 5-11-19	23	9. Birthpi Count MARS	ace (State or Foreign ry) YLAND
faryland show	2	ō	10a. State 10b. County MD BALT	IMORE	10c. City, Town		SEDALE	,				10	0d. Inside City Limits
ith the N or 28a-1	TO SE)irect	10e. Street and Number				Zip Code			1	0g. Citizen	of What Count	
eath w	O ISIN	eral	7907 OAKDALE AVE	NUE 12. Was Deceder	t Ever in U.S.	13 Was Da	212		nin? (Snec	edy Vas or No.		U.S.A.	on Indian
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is narked other than "natural", or items 23a or 28a-f show way intim or other training ages.	Every in the	by Funeral Director	1 Never Married 21X Married 3 Widowed 4 Divorced	Armed Forces 1 X Yes 2 [If Yes, Give Year or Dates] No		specify Cubar	Specify:	, Puerto P	city Yes or No- tican, etc.)		Black, White, e	tc.
21215-0036 ad within 72 hours aff rgiene. er than "natural", or	Note that	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(6	Give kind of ife. DO NO	Isual Occupa work done d Tuse retired)	uring most	of workin	g	16b. Kind o	of Business/Ind	ustry
id 2	aur.	Be Col	17. Father's Name (First, Middle, Last,)		PIP	E MILL		r's Name	(First, Middle, I		HLEHEM	STEEL
ylan ylan ould be Mental arked	מוני	To B	FRANK KLE						CATH	ERINE	(JC	NES)	
and 2 should be file ealth and Mental Hy m 27 is marked oth			19a. Informant's Name/Relationship (79	07 OAI	KDALE A		E I	ROSEDAL	-	wn, State, Zip (21237	
Baltimore, permit. Pages 1 a Department of Her Important: If item	ury or or		20a. Method of Disposition ★★Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif.)		20b. Place of D cemetery, ST. ST	crematory of	or other place		Da 2-8-20			on - City or Tov	
Balt permit. Depart Import	once.		21. Signature of Funeral Service Licer	1500	-						DALE :	FUNERAL	HOME
Physici /Medic			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that cause one cause on each	ine.				cardiac or	respiratory arre	EDALE est,		1237 Approximate Interval Between Onset and Death
Examir	ner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	s a consequence of,								
. BOX 68 /60, death certificate be executed e attending physician and of or use as the burial-transit		ca	resulting in death) Last	Due to (or a	s a consequence of)								
15, P.O. BOX 63 res that the death certific signed by the attending p		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 □ Fetal death at time of death	3 □Ectopio 5 □ Other	pregnancy (specify)				23d.	Date of delivery Month E	y Day Year
The law requires that the tte has been signed by the same 2 should be detached	ŝ.	2	Part II. Other significant conditions of	ontributing to death	but not resulting in th	ne undertyin	g cause give	n in Part I.			oacco use c		cause of death?
	4	e Completed	25. Was case referred to medical						(0) #	24a. Was ar autops perform 1 Yes 2	ned?	Ib. Were autops prior to com- death? 1 \square Yes 2	sy findings available pletion of cause of
OT VIII Physicia this cert		To Be	examiner?	Hospital: 1 ☐ Inpat		atient 3	DOA Other			Check onlone e 5 X Reside		Other (Specify)	
On O ding Ph h. After th		tion:	27. Manner of Death 1. ■ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of In (Month, D	ay Year) 28b. Tim Inju		28c. Injury Work	at ? es 2 □ N	28	d. Vescribe ho			
DIVISION OT VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifical completely filled in by the funeral director.		Certification;	3 Suicide 6 Could not be determined	28e. Place of Ir	njury - At home, farm tc. (Specify)					of. Location (Str City or Town		ımber or Rural i	Route Number,
he Hospit n 24 hours ne Funera		Medical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the bes niner: On the basis and manner s	t of my knowledge, of examination and/otated.	leath occurr or investigati	ed at the time on, in my opi	e, date and inion, death	I place, an	d due to the ca I at the time, da	use(s) and ite and plac	manner as stat ce, and due to t	ed. he cause(s)
Tot		≥	29b. Signature and title of certifier Mod M	Whi	oll		D2	number 4/4	9	25	2/	gned (Month, Da 4 05	ay, Year)
611				now	10 N	rpe, Print)	reen	e S.	+ 1	Balti	more	e MD	21201
Reg	Stat Jistra	e .	31. Date filed (Month, Da), Year) FEB 0 9 200		trar's Signature	1							
DHMH 17 Rev	v 1/200	01	V & U U	5 Jilsen	ORIGI	NAL							

State of Maryland / Department of Health and Mental Hygiene 0 05 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 20 Year HERMAN **EDGAR** KLETN /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner 46 County of Death OSP 5940-10 KOSELO E If Under 1 Year If Under 24 Hrs. **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 🔀 M 2 🗆 F Hours Min. 91 Director 212-05-7595 Yrs 2-2-1914 MARYLAND Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location Itams 23a or 28a-f show the must be notified at 10d. Inside City Limits Completed by Funeral Director MD BALTIMORE ROSEDALE 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1304 ROSEWICK AVENUE 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian other traumatic avent, the Medical Examiners Black, White, etc. 1 Never Married 2 Married ŏ 1 ☐ Yes 2 ☑ No Specify: WHITE 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. STEEL WORKER 8 ARMCO STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ed bluods MICHAEL KLEIN WIRTIE (RYLEY) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 I TERRY CLASING/GRANDDAUGHTER 224 RIVERSIDE ROAD BALTIMORE, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o once. ō 1 Burial 2 □ Cremation 3 □ Removal from State `4 Donation 5 ☐ Other (Specify) OAKLAWN CEMETERY 2-5-2005 BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licenses 1211 CHESACO AVENUE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) N **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the attending physician and the for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death Year 5 ☐ Other (specify) P.O. detached 9□ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ Completed 2 🗆 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy performed? certificate 1 ☐ Yes 2/ No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 0 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 33 0 336 213105 Name and address of person who completed cause of death (item 23a) (Type, Print) 9 Kilmon) Ahmed 591 006 Flanklin 31. Date filed (Month, Day, Year) State Blown & A FEB 09 2005 Registrar

			1 - For Stete Registrer	State of M	arylan		artment			and M		giene Reg. No2	005	03906
	Physici /Medi Examir	cal .	Decedent's Name (First, Middle, Last VIRGINIA 4a. Facility Name (If not institution, give Johns Hopkins Bayne	KAHLI street and number))			Town, or	Location o	f Death	2. Date of De Month February	O3	Year 2005 ounty of Deat	
	Funeral Director		5. Social Security Number 6. Se		ge (In yrs. I	ast birthday) 86 Yrs.	If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 10-21-	h y, Year) 1918	Co	nplace (State or Foreign untry) RYLAND
	th the Maryland or 28e-f show	Director	10a. State 10b. County	IMORE	10c. City	r, Town or Lo		SEDA Code	LE			10g. Citize	n of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☒ No untry?
396	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other then "naturel", or items 23a or 28e-f show or other traumatic event, the Medical Example must be notified at	by Funeral D	8340 OLD PHTLAT 11. Marital Status 1 Never Married 2 Married 3 M Widowed 4 Divorced	DELPHIA RO 12. Was Decedent Armed Forces? 1	Ever in U.S		Vas Deceder f Yes, spec	ent of Hi	spanic Origin, Mexican Specify:	gin? (Spe , Puerto	ocify Yes or No- Rican, etc.)		U.S.A. Blace - Amer Black, White	ican Indian,
Maryland 21215-0036	filed within 72 hou Hygiene. other then "nature ant, the Madical E	Completed	15. Decedent's Edu (Specify only highest grad		5+)		lent's Usual kind of won DO NOT use NER	l Occupa k done d e retired)	tion uring most	of workii	ng		of Business/l	ndustry ESTURANT
ryland	2 should be filed and Mental Hygic Is marked other raumatic event, II	To Be	17. Father's Name (First, Middle, Last) WILLIAM KRAUC 19a. Informant's Name/Relationship (Ty			10h 14a ilia		(2)	AT	LICE	(First, Middle,	(UNK	NOWN)	
	1 and 2 s Health an em 27 Is r ither traur		HENRY KAHLER, JR. 20a. Method of Disposition		20h. Pl		OLD	PHIL		PHIA	ROAD I	ROSEDA	own, State, Z ALE, M tion - City or 1	21237
Baltimore,	it. Pa rtmer rtent njury		1 ☐ Burial 2 ☑ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)		Ce	rnetery, cren	EMATO	her place RY		2-5-2	2005	CATO	NSVILLI	E, MD
Bal	Depa Impo any ii		21. Signature of Funeral Service Licens	th		1	211 C	HESA	CO AV	ENUE		DALE,		1237
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comples shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Due to (or as	ne. SIS a consequ	ence of);	er the mode	of dying	, such as o	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
8760,	certificate be executed uding physician and use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Leasabour injury that initiated events resulting in death) Last	Due to (or as		ence of):								DAYS
.O. Box 6	that the death certific led by the attending p detached for use as I	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal	death 3 🗌	Ectopic pre Other (spe					230	I. Date of delik	rery Day Year
ords, P	w requires that been signed to should be deta		Part II. Other significant conditions cor	ntributing to death b	ut not resu	lting in the un	derlying ca	use give	n in Part I.			bacco use es 2□N		the cause of death?
of Vital Record	The la ate has page 2	Completed										med? 2. No	4b. Were aut prior to co death? 1 \(\sum \text{Yes}\)	opsy findings available impletion of cause of
ion of Vit	ing Phys	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatie 28a. Date of Inju (Month, Da		ER/Outpatient 28b. Time of Injury		c. Injury Work	~ 4 □ Nurs	sing Horr 2	(Check only or ne 5 Reside 8d. Describe he	ence 6		fy)
Division	0 # 5 5	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubul	ury - At hor c. (Specify)	ne, farm, stre	et, factory,	office		2	8f. Location (Si City or Town	treet and N n, State)	lumber or Rur	al Route Number,
	To the Hospitel or within 24 hours after To the Funerel Discompletely filled in	Medical	29a. Certifier (Check only one) Certifying Physical Examination)	sicien: To the best ner: On the basis of and manner sta	r examinati	viedge, death on and/or inv	occurred a estigation, i	t the time n my opi	, date and nion, death	place, a	nd due to the c d at the time, d	ause(s) and ate and pla	d manner as s ace, and due t	stated. o the cause(s)
	To t To t	Σ	29b. Signature and title of certifier Faram	hà ug	}			License D59			1		igned (Month,	
1	201		30. Name and address of person who co	mpleted cause of d	eath (Item	23a) (Type, F	Print) (enter	494	0 Eas	tarn 1	tvenue	Balti	more, H	3. 2005 layland 2122d
S., .	Sta Registr	-	31. Date filed (<i>Month, Day, Year</i>) FEB 0 9 200	32 Registra	ar's Signati	ire do	ull s							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend Item \$1818 of Mary 1884 Department of Health and Mental Hygiene AMEND ITEM#19aPER FH G840 2/11/05 Gertificate of Death Reg. No. 2. Date of Deeth Month **Physician** Year Lewis Javid M. 4:40 PM OZ 06 2005 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Huspital Baltmore Pedratic Baltmore Washington 6. Sex. 1 M M 2□ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Birthplace (State or Foreign Country) **Funeral** Days Months 122-86-7986 Director Usuel Residence of Decedent death with the Maryland 10a. Stete 10b. County pernit. Peges 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Health end Mentel Hygiene. Important: if Item 27 ie marked other than "natursi", or flerms 23a or 28a-f show any injury or other treumatic event, the Modical Examiner must be indiffed at 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE MO N 1 Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? SIAMFORD ROAD USA Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 200 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Specify: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) NA 18. Mother's Neme (First, Middle, Maiden Sumame)

Product Requel Bland 17. Fether's Neme (First, Middle, Last) Be Lewis ပ 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) STREET Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State WOODLAWN 4 ☐ Donation 5 ☐ Other (Specify) 2.10.05 BALTO. MD 22. Name and Address of Fecility VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funeral Service Licenses 5151 BALTO. NATL' PIKE, BALTO, MO 23a. Pert1. Ente the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Multiturne bran months Examiner Examiner physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be asscuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funerel director, page 2 should be deteched for use es the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Medical Certification: To Be Completed by page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Tes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar DHMH 16 Rev 6/95

State

29b. Signature end title of certifier

31. Dete filed (Month, Day, Year)

FEB 09

a.

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) Stephen A. Nichols M.D.

2005

egistrar's Signeture

THE CARE

29c. License number

56863

29d. Date signed (Month, Day, Year)

2005

of Vital Records,

AVYA

After Division after death.

To the Hospital within 24 hours a To the Funeral C

funeral director,

Medical State Registrar

Certification:

29b. Signature and title of certifier MD MWRTAZA KATUI, MD

28a. Date of Injury (Month, Day Year)

and manner stated.

P-17610

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) JANUARY, 29. 2005

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST. AGNES HOSPITAL

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

900 S. CATON AUE, BALTIMORE, ND 21229

28d. Describe how injury occurred

KAZMI, M.D 9 2005

5 Pending investigation

6 Could not be determined

27. Manne of Death 1 Natural

2 Accident

3 Suicide

29a. Certifier

4 | Homicide

(Check only one)

atherin Maryland 21215-0036 Baltimore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Lowe Catherine E. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Square Kosedale tranklin Hospita If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Ade (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1 □ M 2 □ F Director 212-46**-**7866 5,1947 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director <u>Maryland</u> Baltimore Dundalk 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? or Itams 23e 215 Pinewood Road 21222 Completed by Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 2 should be filed within 72 hours after in and Mental Hygiene. Is marked other than "netural", or Itan 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify. 3 Widowed 4 Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Secretary Aerospace 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry F. Stemler ပ Dorothy Sutton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or othar trai <u>once</u>. 215 Pinewood Road Dundalk, Maryland Mr. Robert Lowe Husband 20b. Place of Disposition (Name of Date 20a, Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 2/9/2005 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility anda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Renal Tubular disease or condition resulting in death) Houte /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any taking to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 2 ER/Outpatient 3 DOA Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗍 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Physician: or Attanding death. Diractor: within 24 hours a To the Funaral L To the Hospital Registrar DHMH 17 Rev 1/2001

(Check only one)

29b. Signatur sand title of certifie

riAnastasios Saliaris, 9000 Franklin Square Drive, Baltimore, MD 21237

e and address of person who completed cause of death (Item 23a) (Type, Print)

2005

29d. Date signed (Month, Day, Year)

			1- State Registrar Ce	rtificate of Dooth	giene 2005 03911
П	Physici	an	Decedent's Name (First, Middle, Last) SARA M.	2. Date of De Month LEVY FEBRUA	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			SHADY GROVE ADVENTIST HOSPITAL	ROCKVILLE	MONTGOMERY
١	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 M 2 1 M 5 96 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Bir Months Days Hours Min. 0 C . 2 4	9. Birthplace (State or Foreign Country)
			Usual Residence of Decedent		
	ours after death with the Marylar rel', or items 23e or 28a-1 show Examiner must be notified at	ō	10a. State 10b. County 10c. City, Town or L MD MONTGOMERY ROCK	VILLE	10d. Inside City Limits 1 1\textbf{Y} Yes 2 □ No
	or 28a-	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ath wit		299 HURLEY AVENUE	20850 -20855 -	USA
	items items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 2 Never Married 2 Never Married 1 Never Married 2 Nev	Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
036	within 72 hours after death with the Maryland ene. than "neturel", or items 23e or 28a-f show tha Madical Examina in unit be notified at	by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	Specify: WHITE
15-0	"netu	letec	(Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
212	filed within Hygiene. Other than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	CAL TECHNICIAN	MEDICINE
Maryland 21215-0036	2 2 - 2	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	
ryla	should be and Mental e marked o umatic eve	²	SAMUEL MISL 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ER LENA ing Address (Street and Number or Rural Route Numb	BROOKMAN
	d 2 s th ar 7 le treu			TUPELO DRIVE - ROCKVILL	
Baltimore,	ges 1 a t of Hea If item or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre-	osition (Name of Date matory or other place)	20c. Location - City or Town, State
ţ	permit. Pages Department of Importent: If it any injury or o		`4 □Donation 5 □Other (Specify) ANSHE EM	IUNAH CEMETERY 02/08/05	BALTIMORE, MD
Bal	permit. Pages 1 and Department of Heali Importent: If item 2 any injury or other <u>once</u> .			2. Name and Address of Facility SOL LEVIN 1900 REISTERSTOWN ROAD -	
	-son-		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final		rrest, Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) SEPS a	515	
	Examiner		Sequentially list conditions, b.		
	nsit	Examine	fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
oʻ	cate be executed physician and the burial-transit	Еха	that initiated events c. Due to (or as a consequence of):		
8760,	cate be physici the bu	dical	d		
Box 6	eath certific attending p	a a	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
O.	The faw requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	□Ectopic pregnancy □ Other (specify)	Month Day Year
ds, P	ires tha signed be det	þ	Part II. Other significant conditions contributing to death but not resulting in the	, , ,	obacco use contribute to the cause of death? Yes 2 □ No 3 □ Probably 4 ▼Unknown
Records,	aw requir s been si 2 should l	Completed		24a. Was	
Re	The la	omo		auto perfo	prior to completion of cause of death? 2 No 1 Yes 2 No
Vital	Physician: The this certificate ral director, pag	Bec	25. Was case referred to medical examiner?	26. Place of Death (Check only of	
of	Phys this ral dii	To	1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of		dence 6 Other (Specify) how injury occurred
ion	Attending or death.	atior	1 X Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	of 28c. Injury at Work? M 1 Yes 2 No	
Division	i Dir	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f. Location (City or To	Street and Number or Rural Route Number, wn, State)
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical C	29a. Certifier (Check only 2 Medical Exeminer: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and due to the nvestigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the I within 2. To the I complet	Me	296. Signature and title of Centifler	29c. License number	29d. Date signed (Month, Day, Year)
	1			D0061681	FEBRUARY 6, 2005
h	T		30 me and address of person who completed cause of death (Item 23a) (Type	Print) PROVE ADVENTIST HOS	PETAL ROCKUTUS MD
Í	Sta Registi	-	31. Date filed (Month, Day, Year) See 1. Date filed (Month, Day, Year) 32. Registrar's Signature See 1. Date filed (Month, Day, Year) See 1. Date filed (Month, Day, Year)	hand a	-c. 12 realization (MC)
	riegisti	-ui	LED OF LOUD PROPERTY DE		

			1 - State of Maryland State of Maryland		artment of Ho			giene 2	005	03912
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Rosa V. Lawrence				2. Date of Dea	Day 05	2005	3. Time of Death 12:45 PM
	Examin		4a. Facility Name (If not institution, give street and number) 524 Brisbane Road		4b. City, Town, or Bal	Location of Dea	ith	4c. Cour	nty of Death	
	Funeral Director		5. Social Security Number 218-26-9369 1 □ M 21 1 97 97 1 Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		h V. Year)	9. Birthpl Count Sout	ace (State or Foreign
	<u> </u>		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	cation					Od. Inside City Limits
	the Mar 28a-f sh	Funeral Director	MD N/A Ba	ltimo	10f. Zip Code			10g. Citizen o	of What Coun	Y∰Yes 2 □ No
	s 23a or	eral DI	524 Brisbane Road	T ₄₀ :	2122			US	SA	
5-0036	ours after de ral', or Itams Examiner o	by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Force ? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of His f Yes, specify Cubar I ☐ Yes 2 ☐ No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	В	ace - America lack, White, e cify:B1aCl	etc.
21215-0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show says injury or other traumatic event. The Medical Examinational Examinational Examinational Examinational Examinational Examinational Examinational Examinational Examinational Examinational Examinational Examinational Examination Examinational Examination	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary(Secondary (0-12) College (1-4or 5+)	16a. Deced (Give life. L	lent's Usual Occupa kind of work done di DO NOT use retired) OMEMAKEY	tion uring most of w	orking		Business/Ind	ustry
Maryland 2	should be filed wind Mental Hygien in markad other thumatic event, the	To Be C	17. Father's Name (<i>First, Middle, Last)</i> Henry Peterson			18. Mother's Na Carri	e Brunso	Maiden Sum: N Peter	ame) CSON	
	1 and 2 sho Health and Iam 27 is m		19a. Informant's Name/Relationship (Type, Print) Margaret Fields/Daughter		g Address <i>(Str</i> eet a. 4 Brisban					
Baltimore,	Pages 1 and of Hernort: If itam	9	20a. Method of Disposition 1 Burial 2 **Cremation 3 Removal from State** 1 Donation **3 Other (Specify) Met**	nce of Disponentery, cren	sition (Name of natory or other place ematory, I	nc. 2/8	Date 3/05	20c. Location Baltimo	-	wn, State
Balti	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licenses	22	. Name and Address	s of Facility W	ylie Fun	neral pertyl	Home!	PA of ndallstown
760,	Priysician // // // // // // // // // // // // //	dical Examiner	23a Párt. Enter the disease, or complications that caused the death. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequenc	ence of):	er the mode of dying	NAC		CTICU	Dissas	Approximate MD . Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed te has been signed by the attending physician and orge 2 should be detached for use as the burial-transit	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of decent 2 ☐ Fetal 4 ☐ Fetal	death 3	Ectopic pregnancy Other (specify)	NID	+		Date of deliver	y Day Year
	w requires that been signed b should be dete	by	Part II. Other significant conditions contributing to death but not resul	ting in the ur	nderlying cause give	n in Part I.	23e. Did to	es 2 No	3 ☐ Proba	e cause of death? ably 4 Unknown sy findings available
al Re	: The law cate has page 2	Completed					autop perfo	sy	prior to condeath?	pletion of cause of
Division of Vital Records,	Attanding Physician: The Indeath. actor: After this certificate he by the funeral director, page	tlon: To Be		R/Outpatien 28b. Time of Injury	28c. Injury Work	r: 4 🗆 Nursing	Home 5 Residence 28d. Pescribe h	ence 6 🗆 O)
Divisi	# 00 >	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre			28f. Location (S City or Tow		mber or Rural	Route Number,
	To the Hospital or At within 24 hours after of To tha Funaral Diract completely filled in by	edical C	29a. Certifier (Check only one) Certifying Physicien: To the best of my know 2 Medical Examiner: On the basis of examinati and manner stated.							
)	To th withir To th	Me	29b. Signature and title of certifier W	an	29c. License	number 3619		29d. Date sign	ned (Month, E	ay, Year)
	5		30. Name and address of person who completed cause of death (Item 264) W H UWC	23a) (Type,	Print) Z3d0	ENC	mon B	cus T	3407	disis m
	Sta Registi		31. Date filed (Month Cay Year) 9 2005 32. Resistrar's Signate		Saule J					

			for State Registrar	State of Ma		/ Depa		Health a	and Me	ntal Hygie	•	05	03913
	Physici /Medic		1. Decedent's Name (First, Middle, Last Leland		M	ay				2. Date of Death Month February	Day 2	005°	3. Time of Death 14:15 M
	Examir		4a. Facility Name (If not institution, give Suburban Hospit					n, or Location of thesda	of Death		4c. County Mo	of Death	nery
	Funeral Director		30110313303		e (In yrs. las 93	t birthday) Yrs.	If Under 1 Ye Months Day		Min. Ju	Date of Birth (Month Day,) 11y 11,	T911	9. Birthi Court Nort	place (State or Foreign Try) Dakota
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show fra Madical Examinar must be nutified at	ector	Usual Residence of Decedent 10a. State 10b. County MD Montgome	ery	10c. City,	Town or Lo	a			140	000		0d. Inside City Limits 1√2 Yes 2 □ No
	23e or 2	ral Dir	10e. Street and Number 5100 Dorset Ave	enue Apt.	400		10f. Zip Cod	815		100	U.S.		ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, It a Madical Examinat must be nutified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 1 If Yes, Give Year or Dates:			Was Decedent of If Yes, specify C		gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)	Bla	e - Americk, White,	
21215-0036	within 72 ho ene. then "netur re Medical	ompieted	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)			(Give life.	dent's Usual Oct kind of work do DO NOT use ret	ne during most ired)		Budget	Sb. Kind of B		dustry
Maryland 2	buld be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) Elmer M. May	,				18. Mothe	Pearl	First, Middle, Ma L Mott	aiden Surnan	ne)	
Mar	alth and 2 should be seen and 27 is more seen		19a. Informant's Name/Relationship (7) Lucille B. May/ W				-			400 Che			Code) MD 20815
Baltimore,	Pages 1 a nent of He int: If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 Macremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		20b. Plac cerr Mt.	of Disponence of Comf	sition (Name of matory or other p ort Crem	natory F	Dai eb.9,		c. Location · Lexand		
Balti	permit. Departn Importe any inju		21. Signature of Funeral Service Licens	1. Ber	2	22	2. Name and Ad	dress of Facility	y Jose	ph Gawle e NW WDG			Inc.
760,	Physician // // // // // // // // // // // // //	icai Examiner	23a. Part1. Enter // e disease, or comp shock, only art failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	idications that caused in e cause on each lie a. Pneum Due to (or as b. Due to (or as c. Due to (or as d. Du	on1a a consequer a consequer	nce of);	er the mode of o	tying, such as	cardiac or I	espiratory arres	t,		Approximate Interval Between Onset and Death 2 days
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physicien and cage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	eath 3	Ectopic pregna Other (specify)		, , , , , , , , , , , , , , , , , , , ,		23d. Da Mo	te of delive	ery Day Year
Records, P.	w requires that been signed b should be deta		Part II. Other significant conditions co 		ut not resulti	ng in the u	nderlying cause	given in Part I.					ne cause of death?
		Completed by								24a. Was an autopsy performe	id?		psy findings available mpletion of cause of 2 No
	Phy rthis ral d	n; To Be	27. Manner of Death	Hospital: 1 Stinpation 1 28a. Date of Inju	iry 28	VOutpatier 8b. Time or Injury	28c. Ir	Othor.	rsing Home	Check only one) 5 Residence d. Describe how			y)
	or Attending F after death. Director: After in by the funer	Medical Certification;	1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inj			M 1	Yes 2 1		f. Location (Stre City or Town,	et and Numb State)	er or Rura	l Route Number,
_	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	dicai Ce	29a. Certifier 1 ☑ Certifying Phy (Check only one) 2 ☐ Medicel Exem	sicien: To the best iner: On the basis of and manner sta	f examination	edge, death n and/or in	n occurred at the vestigation, in m	time, date and y opinion, deat	d place, and	d due to the cau at the time, date	se(s) and ma	inner as si and due to	rated. the cause(s)
	To the within To the	Me	29b. Signature and fulls of eartifiler	MD				onse number			I. Date signe		
ŗ	6		30. Name and address of person who co		leath (Item 2		Print)	060117			bruary		
£.	Sta Regist		31. Date filed FEB Day (gar) 200	5 Registr	ar's Sign	9901	Medica	1 Cent	er Dr	. Rockvi	ille, 1	MD 20	850

			1 - For State Registrar	State of Marylan	•	ent of Healti		tal Hygien	2005	03911
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, La:		Morris de Ci	ty, Town, or Location	Tá	Date of Death Month Da	Year 2005	3. Time of Death
	Funeral Director		5. Social Security Number 6. S 212–36–8937 1 Usual Residence of Decedent	ex 7. Age (In yrs. \(\)	last birthday) If Uni Yrs. Month		der 24 Hrs. 8. C	Pate of Birth Month, Day, Year Pt 10,	939 9. Birth	place (State or Foreign ntry) unk
	death with the Maryland me 23a or 28a-f show findst be indiffed at	ctor	10a. State 10b. County MD	unk ^{10c. Cit}	y, Town or Location				unk	10d. Inside City Limits 1nk _{i □ Yes 2 □ No}
	leath with ti ne 23e or 2 must be n	Funeral Director	10e. Street and Number 6 Reiethe 11. Marital Status	12. Was Decedent Ever in U		Zip Code		US	itizen of What Cou SA 14. Race - Ameri	
9600	72 hours after dea "natural", or Itema edical Examination	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		pecify Cuban, Mexi			Black, White, Specify:	etc. hite
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryla to f Health and Mental Hyglene. If item 27 is marked other than "netural" or Itema 23a or 28a-f show or other traumatic event, I'm Medical Examinational Deather at	Be Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) unk		16a. Decedent's U (Give kind of life. DO NOT	work done during n	most of working	unk 166. 4	(ind of Business/In	dustry unk
yland	d 2 should be filed within "h and Mental Hygiene." 7 is markad other than "traumatic event, the Med	To Be (17. Father's Name (First, Middle, Last)				other's Name (Fire			unk
	of Health and 2 is the street of Health and 1 is the street of the stree		19a. Informant's Name/Relationship (Mercy Medical	Center	301 St	. Paul P	lace Bal	timore,		2
Baltimore,	rtmer rtant		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specification of Europe Specification)	Removal from State	Place of Disposition (femetery, crematory of	r other place)	Date	20c. L	ocation - City or To	own, State
Ba	Depa fmpo any le		21. Si nature of Funeral Service Licer Ron 1d S	1//1000	Stat Balt	and Address of Fa e Anatomy imore, MI	Board 6		altimore	Street
	Physician /Medical Examiner		723a. Part L Enter the disease/or comeshock or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death one cause on each line. a. Due to (or as a conseq	de l	ode of dying, such	cardiac or res			Approximate Interval Between Onset and Death
8760,	cate be executed oblysician and the burial-transit	ai Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to or as a consequence. Due to (or as a consequence)						
.O. Box 6	death certifi e attending I id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	.d	I death 3 Ectopic			12-11	23d. Date of delive	ery Day Year
ords, P	w requires that the dea been signed by the a should be detached to	by	Part II, Dther significant conditions o	ontributing to death but not res	ulting in the underlying	g cause given in Pa	art I.	23e. Did tobacco	- N	he cause of death?
Vital Records,	The law ate has b page 2 st	e Completed	25. Was case referred to medical			ne Pli	1	24a. Was an autopsy performed?	prior to co death?	psy findings available mpletion of cause of 2 No
of Vi	8 0 E	To B	examiner? 1 Yes 2		ER/Outpatient 3	OOA Other: 4 🗆	ace of Death <i>Chi</i> Nursing Home		6 □Other (Specif	iy)
ion	fter	ation:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. l	Describe how inju		
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, fact y)	ory, office	28f. L	ocation (Street ar City or Town, State	nd Number or Rura e)	il Route Number,
	e Hospi 24 hou e Funer letely fill	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death occurre tion and/or investigati	d at the time, date on, in my opinion, o	and place, and d death occurred at	ue to the cause(s the time, date an) and manner as s d place, and due to	tated. o the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	9/ =/	2	9c. License numbe	er	29d. Da	ite signed (Month,	Day, Year)
			30. Nar e and address of person who	comple ed cause of death (Item	23a) (Type, Print)	D40	144	Jano	1an 51	2005
			hild, KN ZZY	NO MORA	Madra	1 Court	er '	SOI ST	to pun	21202
	Sta Registr		31. Date filed (Month, Day, Year) (FFR 0 9 200)	. Registrar's Signa	Sperker				,	

5-(00467 - ij	ΝĪΚ	Please	State of Maryland / Department		•	•	
,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	LVIX	1 - For State Registrar		rtificate of Death		g. No.	03915
	Physic	ian	1. Decedent's Name (First, Middle, L			2. Date of Death Month	Day Year	3. Time of Death
	/Medi Exami	cal	Michael Joseph 4a. Facility Name (If not institution, gi		4b. City, Town, or Location of De	JANUARY	20, 2005 4c. County of Death	6:33a M
	LAdiiii	ici	JOHNS HOPKINS HOS	·	BALTIMORE CIT		N/A	
	Funeral Director		5. Social Security Number unk 6.	Sex 7. Age (In yrs. last birthday) 1 ☑ M 2 ☐ F 40 Yrs.	If Under 1 Year If Under 24 H Months Days Hours M	s. Date of Birth (Month, Day, Feb 27,	Year) 9. Birth	place (State or Foreign
	D		Usual Residence of Decedent 10a. State 10b. County			100 27 9		t Virginia
	Maryla f shov	jo	10a. State 10b. County MD	10c. City, Town or Lo				10d. Inside City Limits 1 ▼ Yes 2 No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cou	ntry?
	s 23a	rai	812 N. Bradford		21205		USA	
′0	fter de r item	Funeral	11. Marital Status 1 ☑Never Married 2 ☐ Married	1 □ Yes 2 TXNo	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black, White,	
21215-0036	ours a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: wh:	ite
15-	in 72 h n "natu Aedica	Completed	15. Decedent's E (Specify only highest gi	rade completed) (Give	dent's Usual Occupation kind of work done during most of v DO NOT use retired)	vorking 1	6b. Kind of Business/Ir	ndustry
212	ed within giene. er than *	Com	Elementary/¶egondary (0-12)	College (5-4 or 5+)	chef		food	
	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Me	Be	17. Father's Name (First, Middle, Las			lame (First, Middle, M		
Maryland	should nd Men marke umatic	ဂ္	Robert L. Micl		Puring Address (Street and Number or	rleen R. M:		2 Code)
	and 2: ealth ai m 27 is		Robert Mick/brot		St. Bonfiace La			_
Baltimore,	Pages 1 nent of He int: if iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [nemoval from State -	osition (Name of matory or other place)	Date 2	0c. Location - City or Te	own, State
Itim			 4 □ Donation 5 ☒ Other (Spec. 21. Signature of Euneral Service Lice 	4-	2. Name and Address of Facility			
B	permit. Departr imports any inju		21. Signature of Funeral Service Lice Rona d S.	Wade Director S	tate Anatomy Boa	zd ₁ 655 W.	Baltimore	Street
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	nplications that caused the death. Do not ent	er the mode of dying, such as card	iac or respiratory arres	cu.	Approximate Interval Between Onset and Death
	ed tis	iner	Sequentially list conditions, if any, leading to immediate cause. Lines Underlying Cause (Disease or injury	Due to (or as a consequence of):				
o,	sicien and burial-transit	Examiner	that initiated events resulting in death) Last	c				
68760,	icate be ex physicien s the burial	dicai		d				
P.O. Box 6	ath certif ttending or use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
	quires that the de n signed by the a uld be detached f	by	Part II. Other significant conditions	contributing to death but not resulting in the u	nderlying cause given in Part I.		cco use contribute to to	he cause of death?
of Vital Records,	The law requir cate has been si page 2 should l	Completed				24a. Was an autopsy performe	prior to co death?	psy findings available mpletion of cause of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		eath Check onl one		
o	this al di	1; To	1∑ Yes 2 □ No 27. Manner of Death	28a, Date of Injury 28b. Time of		Home 5 Residen	ce 6 Other (Specificinity occurred	(y)
ion	ath. ath. or: Afte	atior	1 ☐ Natural 5 ☐ Pending investigation	4120765	28c. Injury at Work? A M 1 ☐ Yes 2 ☑ No	SUBTECT	MZ SAW	01
Division	il or Atte after de I Directo d in by th	Certification;	3 ☐ Suicide 6 ☐ Could not to determined	00 - 01 41 44 1-		City or Town	et and Number or Rura State) UN ST, B	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best of my knowledge, death miner: On the basis of examination and/or invand manner stated.	n occurred at the time, date and pla vestigation, in my opinion, death oc	ce, and due to the cau	se(s) and manner as s	tated
	To the within To the comple	Me	29b. Signature and title of certifier	acres creative observer	29c. License number	290	d. Date signed (Month,	Day, Year)
			> ChieIZ_		OCME	J	ANUARY 21,	2005
				completed cause of death (Item 23a) (Type, RUB 10, HD 111 PENN	STREET, BALTIMO	RE, MARYLAI	ND 21201	
	Sta Registi		31. Date filed (Month, Day, Year) FEB 0 9 20	32 Registrar's Signature	ale)			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend isas of Maryland? Departitles of Health and Wental Hygiene 005

03916 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Samuel Mbappe January 23, 2005 3:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mariner Health Circle Manor Kensington Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Aug 23, 1945 9. Birthplace (State or Foreign Country) AITICA 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1⊠M 2□ F 59 Yrs. 212-79-2805 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter daath with the Marylend Department of Haatth and Mentel Hygiene. Important: If them 27 is marked other than "natural; or thems 23a or 28a-f show any Injury or other traumatic evant, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Kensington 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10231 Carroll Place 20895 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: black 3 ☐ Widowed 4 ☒ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) musician entertainment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be Samuel Mbappe Sr ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk Al Kallay/step brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State 4 □ Donation 5 Other (Specify) Freetowne Sierra Leone 3-19-05Freetowne Sierra Leone J.B. Jenkins Funeral Home 22. Name and Address of Facility State Anatomy Board icensee Wade Foard 655 W Baltimore Street 7474 Landover Rd 20785 Landover, Maryland 20785 Baltimore, MD 23a. Part1. Elter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical LUNG CANCER Examiner Due to (or as a consequence of): Examine PULMONARY EMBOLISM attending physician and I for use es the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by tha a should be datachad 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Š 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No Aftar this Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No reral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral D completaly filled 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier en, mo 1124105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Health Circle manor ruon 200 marine 31. Date filed (Month, Day, War) 32. Registrar's Signature State FFB 0 9 2005

Registrar

			1 - For State Registrar	State of Ma	rylan		rtmen tificat			nd M		Reg. No.	05	03917
	Physicia /Medic		1. Decedent's Name (First, Middle, Las	CDANIE		_					2. Date of De Month FEIRU	Day	Year Zot	3. Time of Death 5. 477 M
	Examin		4a. Fecility Name (If not institution, give NONTHWEST	street and number)			4b. City,	Town, or L	ocation of	Death		4c Cou	inty of Deat	
Т	Funeral		5. Social Security Number 6. So		(In yrs.	last birthday)	If Under Months		If Under 2		8. Date of Bir (Month, Da	th	9. Birt	thplace (State or Foreign
Ħ	Director		Usuel Residence of Decedent			10 Yrs.					Feb. 4,	1964	Mai	ryland
	death with the Maryland ms 23a or 28e-f show r must be notified at	ō	10a. State 10b. County MD NA			y. Town or Local Himore	cation							10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	or 28e	Directo	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Co	puntry?
	eath w	Funeral I	2317 Madison A	Ve. 12. Was Decedent E	er in 11	S 13 V	2121		nanio Origi	in? (Spe		USA	Pace - Ame	nican Indian,
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiene. Department of Health and Mantal Hygiene. Department of Health and Mantal Hygiene than "natural", or Items 23a or 28e-f show any injury or other treumetic event, the Madical Examiner must be notified at once.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 2 No If Yes, Give Year or Dates:			Yes, spec		Mexican, Specify:	Puerto F	cify Yes or No Rican, etc.)		Black, Whit	e, etc.
<u>.</u>	n 72 ho "natur	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced (Give	lent's Usua kind of wor OO NOT us	k done du	ion iring most	of workin	g	16b. Kind o	f Business/	Industry
7 7	filed within Hygiene. sther than "	S mo	Efementary/Secondary (0-12)	College (1-4or 5+)	Cosme		,				Salon		
and	d be file	Be	17. Father's Name (First, Middle, Last)								(First, Middle	, Maiden Sun	name)	
ary	should and Men smarke sumetic	2	James R. McDaniel 19a. Informant's Name/Relationship (7)	Type, Print)		19b. Mailin	g Address		Pandor nd Number		Route Numb	er, City or To	wn, State, i	Zip Code)
e, e	1 and 2 Health em 27 I		Cynthia E. McDeniel 20a. Method of Disposition	- wife	20b. P	24 Gre			Balto	D. MD	21207	20c. Locatio	on - City or	Town State
Saltimore	Pages net; If it iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		C	emetery, crem	natory or o	ther place)		-8-0	5	Lansdov		
Salt	permit. Departri Importe any inju		21. Signature of Funeral Service Licen	See /		22	. Name an	d Address	of Facility	•				
	10110		23a. Part . Enjer the disease, or comp shock or heart failure. List only	plications that caused t	he death	n. Do not ente	or the mod	e of dying,	such as c	ardiac or	respiratory a	rrest,	Balro.	MD 31339 Approximate Interval Between
, 1	Physician		Immediate cause (Final disease or condition resulting in death)	a. SyBA		CHNO	D	1-1	EN	1012	RHAC	E		Onset and Death
	/Medical Examiner			Due to tor as a	conseq	uence of):								
۲	pe is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	conseq	uence of):								
ĵ.	ate be executed hysician end the burial-transil	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	conseq	uence of):								
9/60	cate be physicia the bu	dical		d										
O. Box 6	ires that the death certificate be executed signed by the attending physician end be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome o 1□Live birth 2 4□Pregnant at t 9□Unknown	Fete	death 3	Ectopic pr						Date of del Month	ivery Day Year
ds, F.	requires that the een signed by th hould be detache	ρ	Part If. Other significant conditions of	ontributing to death but	not res	ulting in the ur	nderlying c	ause given	in Part I.			obacco use o		the cause of death?
Zec	e law has b	ompleted									24a. Was auto perio		b. Were au prior to death?	utopsy findings available completion of cause of
	ysician: This certificate director, pag	BeC	25. Was case referred to medical examiner?	Hospital:						of Death	(Check only		103	42.110
ō	Attending Physician: r death. sctor: After this certific by the funeral director.	on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day		ER/Outpatien 28b. Time of Injury		8c. Injury a Work?	4 🗀 Nurs		ne 5 🗆 Resi 8d. Describe			cify)
UIVISION	Attendia death. ctor: A y the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injur	y - At ho	ome, farm, stre	М	1 🗆 Ye	es 2□N		8f. Location (Street and Nu	ımber or Rı	ural Route Number,
É	itel or arter rel Dire		Tolliode	building, etc.	(Specify	v)					City or To	wn, State)		
	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	edical	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exen	ysicien: To the best of niner: On the basis of and manner stat	examina	tion and/or in	onitontine.	in and	aine dante		of and alone at	d-4 d-1-	manner as e, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1 0	10		290	. License	number	2 2		29d. Date sig		h, Day, Year)
1	1		30. Name and address of person who	completed cause of de	ath (Item	23a) (Type.	Print).	15	13-	25	211	7-13	TOUA	ry 2, 7005
	11'		C AA	VI MP	. 1	ette,	.34	170	N	(1)	211:	کے		
	Sta Registr		31. Date filed (Month, Day Year) FEB 0	9 2005 Regist	S Signa	ture J.	Apre	w						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 3 **Physician** Marion E. Milligan February 2005 3:45 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6 W. 14th Avenue Baltimore Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 24, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Director 214 36 9513 66 1938 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28e-f show the Medical Examinar must be notified at 10d. Inside City Limits Director Maryland Anne Arundel 1 ☐ Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 W. 14th Avenue 21225 U.S. death Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours efter Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry permit. Pages 1 and 2 should be flied within 72. Department of Health and Mental Hygiene. Importent: if tiem 27 is marked other than "na any injury or other traumatic event, the Media once. Elementary/Secondary (0-12) College (1-4or 5+) Clerica1 12th Wards 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Furman Lutz Blanche Grimes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alvin Milligan / Husband 6 W. 14th Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crestlawn Mem. Gardens 2/5/2005 Marriottsville, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee fromerouse 4001 Ritchie Highway Baltimore, Maryland 21225 10 mme 23a. Park. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Claus Conces Priysician (O year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine signed by the attending physician and I be detached for use as the burial-transit be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4☐ Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl. one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2/4/05 024356 1163 Limitelin Seever 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Concer Centy Boltima MD 21237 WM. C. WATERAELD Weinberg 32. Registrar's signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State of Mary		irtment of F			giene	0.000
			1. Decedent's Name (First, Middle, Last)					2. Date of De	-	Year 3 Time of Death
	Physicia /Medic		CHARLES	M	MU	JLLIN		Februer		2005 7:15 PM
	Examin		4a. Facility Name (If not institution, give s.				r Location of Dea	th	4c. County	
			3309 Michelle Ct.	Trailer #		Lansdown				imore
	Funeral Director				yrs. last birthday) 48 Yrs.	Months Days	If Under 24 Hrs Hours Min		y, Year 956	9. Birthplace (State or Foreign Mary Land
	and and	}	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	Mary f sho	ō	Maryland Baltimon	ce	Lansdown	2				1 ☐ Yes 2X No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country?
	h with	Ē	3309 Michelle Ct.	Trailer #	10	21227		1	U. S. A.	
	deat	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13. V	Vas Decedent of H	lispanic Origin? (Specify Yes or No	- 14. Rac	e - American Indian,
9	or it	by Funeral	1X Never Married 2☐ Married	1 ☐ Yes 2X☐ No If Yes, Give	1	Yes 2 XNo		ito i lioan, etc.)	Specify	ck, White, etc. :: White
Ö	ural',	q p	3 Widowed 4 Divorced	Year or Dates:						
<u>.</u>	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notilled at	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	lent's Usual Occup kind of work done DO NOT use retired	during most of wo	orking	16b. Kind of Bu	usiness/Industry
7	withi iene. than	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Meat (-/		Butche	r
Ö	Hyg other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle		
<u>a</u>	Abnta Abnta rked	To B	John Edward Mullir	1			Mary	Madeline	e Promut	ico
ary	and has ma		19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street	and Number or R	ural Route Numb	er, City or Town,	State, Zip Code)
<u>√</u>	and ealth m 27		Christine Mullin,			Light St	reet Ba			
Baltimore, Maryland 21215-0036	ges f t of H if ita or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	-	natory or other plac		Date		City or Town, State
Ħ	t. Pa rtmen rtant:		`4 □Donation 5 □ Other (Specify)		Bayview (iew, MD
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any njury or other traumatic evant, the Medical Examiner must be notified at an ance.		21. Signature of Funeral Service License			Name and Addre				
		-	23a. Part1. Enter the disease, or complic	cations that caused the	death. Do not ente	719 Hammo	onds Feri	cy Rd. 1	Lansdown rrest.	Approximate
	Pnysician -		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	and the	•		. ,	·	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a co	nsequence of):					4 years
	Examiner		Sequentially list conditions	Hosti	tis C					Orkanis
	p =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to or as a co	nsequence of):					
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		negguenes of):					
8760,	icate be executed physician and s the burial-transit	aiE		D00 to (or as a co	risequerice or).					
687	ficate phys s the	edicai	d							
Box (eath certifii attending p	N/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of p					23d. Dat	te of delivery
m	death e atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ 4 Pregnant at time		Ectopic pregnancy Other (specify)	/ 		Moi	,
P.O.	that the de ed by the detached	hys	9 □ Unknown	9□ Unknown						
	Se us	by	Part II. Other significant conditions con-	tributing to death but no	ot resulting in the ur	nderlying cause giv	en in Part I.			ribute to the cause of death?
ord	w requir been si should I	ted	D'abetes					1 🗆	Yes 2 No	3 Probably 4 Donknown
ec	has b	Completed	HIV					24a. Was autop	osy g	Were autopsy findings available prior to completion of cause of
<u></u>	r. The							1 ☐ Yes		death? 1 ☐ Yes 2 ☐ No
Ž	siciar certif recto	o Be	25. Was case referred to medical examiner?	ospital:	- 2	Oth	oc.	ath Check onl		
Division of Vital Records,	r this	\vdash	1 ☐ Yes 2 No	28a. Date of Injury	28b. Time of	, all box	4 140131119		dence 6 🗌 Othe how injury occurr	
on	nding th. :: Afte	atior	1.XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ar) Injury	28c. injur Wor M 1	k? Yes 2 ☐ No		, , ,	
Vis	Attendi	iffice	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, stre	eet, factory, office				er or Rural Route Number,
Ö	tal or A	Certification:	4 _ Nomode	building, etc. (c	респу			City or To	WII, SIAIO)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier Certifying Physics (Check only one)	sician: To the best of m ner: On the basis of exa and manner stated.	amination and/or inv	occurred at the tir restigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place, a	inner as stated. and due to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed	d (Month, Dey, Year)
	//	>	X	VL		200	5723	7	Februar.	, 3, 2005
1	100		30. Name and address of person who col			Print)			~	7 3, 2005
			31. Date filed (Month Day, Year)	olit (p)	N. Carol	ine St	rect	Boltino	ore Mi	21287
	Sta Registr		31. Date filed (Month Day, Year) 9 2	1005 Jeses	Signature &	your				

5	ر		1 - For State Registrar	State of Maryland	•	nt of Health an	d Mental Hy	giene 005	03920
	Physici /Medic		1. Decedent's Name (First, Middle, Last MARTHA	NERZON			2. Date of De	LAKES 6, YESS	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, give Northwest Hos	pital	/	Baltimo	re	4c. County of Death Bulti	more
	Funeral Director		111.00.0102	7. Age (In yrs. las	t birthday) If Unde Months	r 1 Year If Under 24 Days Hours N	Hrs. 8. Date of Bit (Month, De 24)	rth ay, Year) 9. Birth Con	nplace (State or Foreign untry)
	Maryland I-f show	tor	Usual Residence of Decedent 10a. State 10b. County N		Town or Location)			10d. Inside City Limits 1 Yes 2 □ No
	th with the 23e or 28e	Funeral Director	10e. Street and Number 3855 Greenst	oring Ave. #	121 10f. Zij	21211		10g. Citizen of What Cou	untry?
9036	be filed within 72 hours after death with the Maryland nat Hygiene. Ind Hygiene. Indoordher than "natural", or Items 23e or 28e-f show event, the Medical Erran first must be multiplied at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 KNo If Yes, Give Year or Dates:	13. Was Dece If Yes, spe 1 \(\subseteq Yes	dent of Hispanic Origin' cify Cuban, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	o- 14. Race - Amer Black, White Specify: 2	e, etc.
Maryland 21215-0036	I within 72 h liene. r than "natu the Mydical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		life. DO NOT u	ork done during most of	working	Ba Himore Public	
yland 2	should be filed nd Mental Hygid marked other umatic event, th	To Be C	17. Father's Name (First, Middle, Last) John Jones	3		Many	Wyatt	, Maiden Sumame)	
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (T) TEVESO Saleem	/N/ece	1510 Cant	Well Road	T Baltir	per, City or Town, State, Z NOTE MD 2	1244
Baltimore,	Pages 1 nent of He int: If iter iry or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify,	Removal from State		ational 02	2. []. US	Laurel	MD
Balti	permit. Pages Department of H Important: If ite any injury or of		21. Signature of Funeral Service Licens		Vaugh SISU	nd Address of Facility Altimore)	2 Funera National	1 Services Pike Balto	. MD 21229
3	Prysician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused the death. ne cause on each line.	Do not enter the mod				Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	NIA				
	ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence. Due to (or as a consequence.					
8760,	icate be executed physician and s the burial-transit			d					
O. Box 6	death certif e attending ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deal 9 □ Unknown	eath 3 □Ectopic p			23d. Date of deli Month	very Day Year
Q.	es the gned be de	by	Part II. Other significant conditions co	ntributing to death but not resulti	ing in the underlying o	cause given in Part I.		tobacco use contribute to	the cause of death?
Il Records,	The ate h page	Completed					24a. Was auto perfe 1 🗆 Yes	s an 24b. Were aut prior to commed? death? 1 □ Yes	topsy findings available ompletion of cause of
Vital	6 6	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Dinpatient 2 ☐ EF	R/Outpatient 3□ D0	Other	Death (Check only	one) idence 6 □Other (Spec	2.1
ion of	ng fter ne	H .	27. Mapner of Death 1 Natural 5 Pending 2 Accident investigation	THE RESERVE AND THE PARTY OF TH		28c. Injury at Work? 1 Yes 2 No		how injury occurred	ny)
Division	al or Attendii s after death. Il Diractor: A id in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factor	y, office	28f. Location (City or To	(Street and Number or Ru wn, State)	ral Route Number,
	To the Hospital or Atti within 24 hours after de To the Funeral Diracti completely filled in by t	edical C	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	sician: To the best of my knowled iner: On the basis of examination and manner stated.	edge, death occurred n and/or investigation	at the time, date and p , in my opinion, death o	lace, and due to the occurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1: 7	29	c. License number		29d. Date signed (Month	, Day, Year)
	7		1 Programme			14450	,7	+ EBICUATUS	6,2005
	U		/A:J.	ompleted cause of death (Item 2	(Type, Print)	- DEP	T, OK 1	29d. Date signed (Month FEBILLATE) WEDI CINE	, NWHC
	Sta Registi		31. Date filed (MEBay0°9') 200	15 Signal Signal					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#6,10c State of Maryland, Bepartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year NOVAKOWSKI 4.55AM EBRUARY 8 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTH ARUNDEL HOSPITAL GLEN BURNIE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) MAY 18, 1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 X F 80 MARYLAND 219-14-2354 Yrs. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits GLEN BURNIE Ferndale MARYLAND ANNE ARUNDEL 1 ☐ Yes 2 No Completed by Funeral Director 2 3rd Avenue South 10f. Zip Code 10g, Citizen of What Country? 21061 21230 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ဤYes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CABLE WORKER MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ALEXANDER NOWAKOWSKI MARTHA WIESNIEWSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MATILDA M. NOVAKOWSKI/ WIFE 2 3RD AVE., FERNDALE, GLEN BURNIE, MARYLAND 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State FEB. 2005 METRO CREMATORY, INC. ponation 5 Sther (Specify) CATONSVILLE, MARYALND 21. Sign re o weral Se lice Ligensee ²². Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 23a. Part1. Exter we disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CORONARY ARTERY I MONTH Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CARDIAC HYPERTENSION TAMPONADE 1 Yes 2 No 3 Probably 4 Unknown Be Completed PERICAR DIAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? BYBASS LORONARY ARTERY GRAFTING 2 \ No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed use as the burial-tran Box 68760, attending physician P.O. | à Division of Vital Records, Hospital or Attanding Physician: this After after death. filled in by 24 hours a Funaral L completely within 2 To the To the

Funeral

Director

28a-f shov

traumatic avant, the Medical Examinar must be notified at

Physician

/Medical

Examiner

State Registrar

Medical

31. Date filed (Month, Day, Year) FEB 0 9 2005

29b. Signature and title of certifier

29a. Certifier

(Check only one)



1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

1051104

MARYLAND

29d. Date signed (Month, Day, Year)

FRBRUARY 8 2005

		Please	-			artment of H		-	rienes e	•
		For State Registrar	State of	iviai ytariu		tificate of l		wieritai i iy	Reg. No.	03922
		Decedent's Name (First, Middle, Las	t)					2. Date of De	aath	3. Time of Death
Physicia /Medica		Calvin T. Nash						Month FEBRUAR	LY 06, 200	
Examine	_	4a. Facility Name (If not institution, give	street and numb	oer)		1	Location of Deat	h	4c. County of De	eath 10.7
		NORTH ARUNA 5. Social Security Number 6. Se	JEL 1719.	Age (In yrs. las	st hirthday)	GLEN E	MKNL If Under 24 Hrs.	8 Date of Bi	ANNE)	Inthplace (State or Foreign
Funeral Director		213-26-2545	X 7. □M 2□F	7		Months Days	Hours Min.	May ch	27 ^(ear) 1930 M	Tyland
pug 🛊		Usual Residence of Decedent 10a. State 10b. County		10c. City	Town or Lo	cation				10d. Inside City Limits
Marylan f show	ō	Maryland Anne Aru	ındel		en Bu					1 □ Y <i>e</i> s 2√□ No
h the	irec	10e. Street and Number				10f. Zip Code		_	10g. Citizen of What	•
d 21215-0036 d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itams 23a or 28e-f show ant, the Modical Ex. offer out the notified at	Funeral Director	404 Joyce Drive				21061			United Sta	
ter de	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Force 1 Yes 2	ent Ever in U.S. es? ETNo	- 1	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puerl	pecify Yes or No o Rican, etc.)	o- 14. Race - Ar Black, W	nerican Indian, hite, etc.
5-0036 72 hours att	þ	3 Widowed 4 Divorced	If Yes, Give Year or Date			1□Yes 2☐No	Specify:		Specify: W	nite
5-003 72 hours "netural",	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Deced (Give	lent's Usual Occupa kind of work done of OO NOT use retired	ation during most of wo	rking	16b. Kind of Busines	ss/Industry
Ind 21215-C be filed within 72 h tal Hygiene. Id other than 'netu	dmo	Elementary/Secondary (0-12)	College (1-4	lor 5+)	Mecha		1)		Automotiv	ve Industry
ALVIN laryland 212: 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the manal the m	Be Co	17. Father's Name (First, Middle, Last)	-				18. Mother's Nar	ne (First, Middle	, Maiden Sumame)	
ALVII	To E	Charles Nash					Sue Ca	rnes		
Mar.		19a. Informant's Name/Relationship (7							per, City or Town, State	
SH CAL Iore, Maryla ges 1 and 2 should t of Health and Mer If Itam 27 1s marke or other traumatic		Catherine Nash -	wile	20b. Pla	ce of Dispo	sition (Name of	Febr	n burni. Wery	e, Maryland	
HSH mor Pages nent of I		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify		ate Glen	Haveı Haveı	natory or other plac n Mem. Pk	: <i>8)</i> '	-	Glen Burnie	e, Maryland
MASH (Baltimore, N permit. Pages 1 and Department of Health Important: If Item 27 eny injury or other transcene		21. Signatur of Funeral Service Licen			K2	in the land areas	aafek Fu	neral H	ome P.A.	
a 88 5 5 8			saugh						len Burnie	
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	_					or respiratory a	rrest,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a	r as a conseque		ONE W	EEK			
Examiner		Convertible list conditions	CHEON	VIL OF	STRU	crive 1	PULMON	ARY 1	DISEASE	
\	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		r as a conseque						
60, be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or	r as a conseque	ence of);					
	caiE		d							and the same of th
rdifficat	Medi	IF FEMALE:								
Records, P.O. Box 68 The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months?		h 2∐Fetalo	teath 3□	Ectopic pregnancy	,		23d. Date of o Month	delivery Day Year
P.O. nat the de d by the s	ysic	1 Yes 2 No	4∐Pregnar 9☐ Unknow	nt at time of dea vn	ith 5L	Other (specify)				
15, P.O. I res that the de signed by the a	by Pr	Part II. Other significant conditions of	ontributing to dea	th but not result	ting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use contribute	to the cause of death?
cords w require been sig	ted k							1/2	Yes 2□No 3□	Probably 4 □Unknown
lecc law ra las be e 2 sh	Completed							24a. Was	psy prior t	autopsy findings available completion of cause of
al R								1 ☐ Yes		es 2 No
Vit sician s certifi	o Be	25. Was case referred to medical examiner?	Hospital:	patient 2□E	B/Outpatier	t 3FT DOA Oth	26. Place of Dea		one) idence 6 □Other (S)	necify)
n Of ng Phy ter thii	\vdash	27. Manner of Death	28a. Date of (Month,		28b. Time of		y at		how injury occurred	occury)
Sion landir eath. or: Af	catlc	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be				M 1 🗆	Yes 2 □ No			
Division of Vital Records, i or Attanding Physician: The law requires that dash. Director: After this certificate has been signed in by the funeral director, page 2 should be contained to the funeral director.	Certification:	4 Homicide determined	286. Place 0	f Injury - At hon g, etc. <i>(Specify)</i>	ne, farm, str	eet, factory, office			(Street and Number or wn, State)	Rural Route Number,
Spital	62	29a. Certifier 1 Certifying Ph	ysician: To the b	est of my know	ledge, deatl	occurred at the tim	ne, date and place	, and due to the	cause(s) and manner	as stated.
Division of Vital Recont the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical Exam	niner: On the bas and manne	sis of examination stated.	on and/or in	vestigation, in my o	pinion, death occu	rred at the time,	, date and place, and d	ue to the cause(s)
To I To I	≥	29b. Signature and title of certifier	1	_ ^	4 . A	29c. License	e number	,	29d. Date signed (Mo	nth, Day, Year)
σ_i		beleke ka	SJ C Lu	of death (line)	220)/7:00	DOO.	1597.)	FEBRUARI	1 06,2005
10		Zeleku Desse	1500 \$	Utherla	and	HIII W	Ay SIN	er spr	ing ML	20904
Sta	te	(Check only 2 Medical Examone) 29b. Signature and title of certifier Cleke Ca 30. Name and address of person who 201010 Desse 31. Date filed (Month, Day, Year) FEB 0 9 20	105 32. Je	gistrar's Signatu	7 1	north				
Registr	ar	LED 0 3 70	100	~ ~~	1	and a series				

	1	For State Registrar	State of Mary	land / De	partm		lealth and		•	ne 200	5 0392
Physician /Medical		1. Decedent's Name (First, Middle, La	th N	stre!				Ja	ate of Death lonth [Day Y	
Examiner	ľ	la. Facility Name (If not institution, giv Augsburg Luthera			3	ity, Town, o altim	r Location of Dea Ore	th	•	4c. County of Balt:	Death imore
Funeral Director		5. Social Security Number 6. S 214-14-2543 Usual Residence of Decedent	7. Age (in 88	yrs. last birthda Yrs.	Mont	der 1 Year hs Days	If Under 24 Hrs Hours Min	8. Da (N Jul	ate of Birth fonth, Day, Yea ne 18,	1916	Birthplace (State or Forei Country) New Jersey
e Maryland Se-f show Ulfied at		10a. State 10b. County MD Balti		c. City, Town or		Ltimor	e				10d. Inside City Limi
3a or 2a		10e. Street and Number 6811 Campfield R	oad		10f.	Zip Code	21207		10g. (Citizen of Wh	sat Country?
72 hours after death with the Maryland natural", or items 23a or 28e-f show lical Examinational Examinational Director	1212	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	in U.S. 13		ecedent of H specify Cuba s 2 No	ispanic Origin? (s in, Mexican, Puel Specify:	Specify Y to Rican	es or No- , etc.)	14. Race - Black,	American Indian, White, etc. White
ed within 72 hours a ygiene. Ner then "natural", ont, the Majical Examit, the Majical Example Completed by		15. Decedent's E (Specify only highest gra	ide completed)	16a. Dec	edent's l	Isual Occup work done of Tuse retired	ation during most of wo	orking	16b.	Kind of Busi	ness/Industry
giene.		Elementary/Secondary (0-12)	College (1-4or 5+) 5+			eache				educa	ation
ges 1 and 2 should be filed within 72 hours 10 Health and Mental Hygiene. If item 27 is marked other then "natural;, or other treumatic event, Its Marical Exp	3	17. Father's Name (First, Middle, Last, Rudolph S. Resst					18. Mother's Na Clara A	nna	Sophie	Pieper	r
d 2 sho th and ?7 is mu treum		19a. Informant's Name/Relationship (Rudolph Ressmeyer	• • • •	1			and Numberor R rive Qui				ate, Zip Code)
permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tree once.	-	20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 XDonation 5 Other (Specif	Removal from State	Ob. Place of Dis cemetery, cr	position (Vame of		Date			ity or Town, State
permit. Page Department of Importent: If any injury of once.		21. Signature of Funeral Sergice Licer					SolFaoBoar MD 212		5 W. Ba	ltimo	re Street
Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line. a			node of dyin	1	c or resp			Approximate Interval Between Onset and Death
<u>-</u>		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a cor	nsequence of):				-1			
D D D D		resulting in death) Last	Due to (or as a cor	nsequence of):							
The law requires that the death certificate ate has been signed by the attending phys page 2 should be detached for use as the completed by Physiclan/MedIc.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pri 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopio	pregnancy (specify)				23d. Date of Month	
quires that the de na signed by the a uld be detached for a by Physic		Part II. Other significant conditions o	ontributing to death but not	t resulting in the	underlyin	g cause give	en in Part I.	2:	3e. Did tobacco		ute to the cause of death? ☐ Probably 4 ☐Unknow
The law requir cate has been si page 2 should	-							į	ia. Was an autopsy performed?	prid	re autopsy findings available to completion of cause of the the the the the the the the the the
Physicien: this certificatal director,	:	25. Was case referred to medical examiner? 1 ☐ Yes 2 ₺No	Hospital:	•		Othe	26. Place of De			. =-	
After fune		27. Manner of Death 1	28a. Date of Injury (Month, Day Yea	2 ER/Outpation 28b. Time Injury	of	28c. Injury Work	4) Nursing F	1	Residence		
To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After t completely filled in by the funers. Medical Certification:		3 Suicide 6 Could not b determined	28e. Place of Injury - Abuilding, etc. (Sp.	At home, farm, soecify)	street, fac	ory, office			cation (Street a ty or Town, Sta		or Rural Route Number,
ithin 24 hound the Funer of the Funer ompletely fill		29a. Certifier to Certifying Phase (Chack only one) 2 Medicel Exer	ysicien: To the best of my niner: On the basis of exar and manner stated.	knowledge, dea mination and/or i	ath occurr investigat	ed at the tim on, in my or	e, date and place pinion, death occu	and du urred at ti	e to the cause(ne time, date ar	s) and mann nd place, and	er as stated. I due to the cause(s)
To th withir To th comp		29b. Signature and title of certifier				29c. License	_	_			Month, Day, Year)
	-	Name and address of access in	completed cause of death	(Itom 22a) 7	Defen)		03757	3	50	brag	11,2005
		30. Name and address of person who	25 Mai	in 5t=	R	eisteus	town	MD		36	
State Registrar		31. Date filed (Month, Day, Year) FFB 0 9 200	Registrar's S	ignature do	ast s	4					

			1- State of Maryland / Department of Certificate o		al Hygiei	61115	03924
	Physici		1. Decedent's Name (First, Middle, Last) Wicholls	2. Da	ate of Death	Day Year	3. Time of Death
	/Medic Examin Funeral Director			rs Hours Min. (M	ate of Birth fonth, Day, Ye	Ac. County of Deal BALTIN 9. Bin Co	
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Baltimore Catonsville				10d. Inside City Limits 1 ☐ Yes 2 1 No
	th with the P 23s or 28e-	ai Director	10e. Street and Number 10f. Zip Code 16 Fusting Avenue	21228	10g.	Citizen of What Co	l
9800	hours after deeth with the Maryland tural; or itams 23a or 28e-f show al Eventh or must be notified at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes, specify C 11 Yes, Sive Year or Dates:	of Hispanic Origin? (Specify Y uban, Mexican, Puerto Rican, do <i>Specify:</i>	es or No- , etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
21215-0036	be filed within 72 hours after deeth with the Marylan Ital Hygiene. Id other than "natural", or itams 23a or 28e-f show evant, the Medical Evantiar marke anothing at	Completed by	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use return to the control of the con	ne during most of working	unk 16b	. Kind of Business	Industry unk
Maryland		To Be	17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stre	18. Mother's Name (First			unk Zip Code)
Baltimore, Ma	permit. Peges 1 end 2 should Department of Health and Mer Importent: If Item 27 is marke any injury or other treumetic <u>Qnce.</u>		Catonsville Commons 16 Fusting A 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in state	venue Catonsv	ville,	MD 21228 Location - City or	3 Town, State
Balt	permit. Departimporti		21. Sign. lur. Truneral Trice Licensee and Add. Director State Ana Baltimore		5 W. Ba	altimore	
	Pnysician /Medical		23a. Part Enter the disease, of complications that caused the death. Do not enter the mode of dishock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		oratory arrest,		Approximate Interval Between Onset and Death
8760,	Examine be executed by sician and the burial-transit	dicai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	A			DAYS
.O. Box 6	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (specify)			23d. Date of del Month	ivery Day Year
cords, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I. 2	3e. Did tobaco	_	the cause of death?
Vital Neco		e Completed	25. Was case referred to medical	1	4a. Was an autopsy performed □ Yes 2	prior to death?	atopsy findings available completion of cause of
of Vii	Physician: this certificatal director, I	To B	examiner? 1 Yes 2 No	26. Place of Death (Che Other: 4 ursing Home 5		6 ☐ Other (Spe	cify)
Division o	il or Attending P after death. Director: After t d in by the funera	Certification:	3 Suicide 6 Could not be	Yes 2 No	escribe how in	njury occurred and Number or Ru	ural Route Alumbas
Div	oitel or Aurs after arei Dire		4 Homicide building, etc. (Specify)	C	ity or Town, St	ate)	
	To the Haspitei or A within 24 hours after To the Funerei Dire completely filled in b	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the position occurred at the position occurred at the position occurred at the position occurred at the position occurred at the position occurred at the position occurred at the position occurred at the position occurred at the position occurred at the position o	time, date and place, and du popinion, death occurred at t	ue to the cause the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	With To	Z	11010	58457		Date signed (Month	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NANA CEASAR; 821 NORTH EUTAW	STREET, BE	TIMI	DRE M	021201
٤٠	Sta Registi		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NANA CEASAR; 821 NORTH EUTAN 31. Date filed (Month, Day, Year) FFB 0 9 2005 32 degistrar's Signature				

. , po oi i i i i i i i oi o	ion indonate inte	Eliouio Ali	oopico Aio	Legion
State of Maryland	Department of H	ealth and Me	ental Hygien	e2 11 11

		•	For State Registrar	State of Ma		artment of Health rtificate of Death	and Mental Hygi	ene2 () () 5 g. No.	03925
	Physic	an	Decedent's Name (First, Middle, Last)		-		2. Date of Death Month		3. Time of Death
1	/Medi	al		leidert			February		
	Examir	er	4e. Facility Name (If not institution, give : Corsica Hills Cer			4b. City, Town, or Location Centrevi		4c. County of Dee Queen	
	Funeral		5. Social Security Number 6. Sec		(In yrs. last birthday)	If Under 1 Year If Unde	r 24 Hrs. 8. Date of Birth	9. Bir	thplace (State or Foreign
*1	Director		213-03-0000]M 2X)F	86 Yrs.	Months Days Hours	Min. Aug. 30	7918	MD MD
	and		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation			10d. Inside City Limits
	Marylan f show	ō	Maryland Queen A	n l	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Centrevil	او		1 Yes 2 No
	with the Marylar a or 28e-f show be notified at	Director	10e. Street and Number			10f. Zip Code		g. Citizen of What Co	
	th with	al D	205 Armstrong Ave	enue		21617	7	USA	4
920	or itema	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ XWidowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 XN If Yes, Give Year or Dates:	0	Was Decedent of Hispanic Of Yes, specify Cuban, Mexica 1 ☐ Yes 2 ☑ No Specify		14. Race - Ame Black, Whit Specify: W	
5-0	72 hours "natural"	eted	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Dece	dent's Usual Occupation	st of working	6b. Kind of Business	/Industry
121		Completed	Elementary/Secondary (0-12)	College (1-4or 5-		kind of work done during mo DO NOT use retired) /ice Represent		C&P Telep	hono
2	filed v Hygie ther t	ပ္	17. Father's Name (First, Middle, Last)				ner's Name (First, Middle, Ma		mone
Maryland 21215-0036	s 1 and 2 should be filed withing theatth and Mental Hygiene. Item 27 is marked other than other traumatic event, the Mental and the Mental a	To Be	James Edward			Ama	anda Tayına	an	
	nd 2 s lith an 27 is r r traus		James W. Neidert	(son)			Easton, MD 2		ZIP Code)
ore,	of Height Fitem		20a. Method of Disposition			sition (Name of natory or other place)		C. Location - City or	Town, State
Ē	nit. Page partment o ortant: If injury or in.		1 ⊠ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Jn.Meth. Cem.		asadena.	Marvland
Baltimore,	permit. Peges 1 end : Department of Health Important: If item 27 any injury or other tr. 2008.		21. Signature of Funeral Service Virens	5		2. Name and Address of Facil 3111 Mountain		s Funeral	Home, P.A.
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart fature. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	consequence of):	Alzheumi	s cardiac or respiratory arres	t,	Approximate Interval Between Onsel and Death
,8760,	cate be executed obysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):				
O. Box 6	death certific e attending p id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	Petal death 3	Detopic pregnancy Other (specify)	- T.	23d. Date of del Month	ivery Day Year
rds, P	Se es	ρ	Part II. Other significant conditions cor	tributing to death bu	t not resulting in the u	nderlying cause given in Part		12.	the cause of death?
<u> </u>	The law ate has b page 2 sl	Completed					24a. Was an autopsy performe 1 ☐ Yes 25	prior to	itopsy findings available completion of cause of
Vita	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	oonitel:			e of Death (Check only one)	×	
of	Phys this	- To	1 ☐ Yes 2 ☐ No h	ospital: 1 Inpatier			ursing Home 5 Residence		cify)
on	Jing After fune	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 200. 18me of Injury	28c. Injury at Work? M 1 Yes 2	28d. Describe how	mjury occurred	
Division	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	ry - At home, farm, str. (Specify)			et and Number or Ru State)	ıral Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical	one)	nician: To the best of ner: On the basis of and manner stat	examination and/or inv	n occurred at the time, date an vestigation, in my opinion, dea	nd place, and due to the cau ath occurred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the To the Communication of	Σ	29b. Signature and title of Pertifier	ans		29c. License number		Date signed (Month	h, Dey, Year)
1	100		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) Type,	Brint) 0320		2///0	(8)
_	1 *		31. Date filed (Month, Day, Year)	222 0	5108 175	war bra	e Chile	° 1, 51	419
	Sta Registi		S1. Date filed (Moriti, Day, Fear)	32. Registra	s signature	Sporter			

					State of M	aryland /		tment of F <i>ificate of</i>	lealth and M Death		/	05	03926
	Physic		1. Decedent's Name	(First, Middle, Las	st)		Na	dolny	- Catri	2. Date of De Month	Day	Year	3. Time of Death
	/Medi Examir Funeral Director		4a Fecility Name (M) 5. Social Security Nu 213-26-47	mber 6. S	Vurshin	e lin yrs. last b	fems inthday) Yrs.	If Under 1 Year Months Days	4b. City, Town, or L Bala If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De	h 46. County o	of Deeth imor 9. Birthpl	re Co. lace (State or Foreign try)
	pue &		Usuel Residence of [10a. Stete	Decedent 10b. County		10c. City, Tox	wn or Loca	ition					Od. Inside City Limits
	Mery Find	ţō	Maryland	Balt	imore				Dur	ndalk			1 ☐ Yes 2√€ No
	th with the 23a or 28	ai Director	10e. Street end Num 4051 St	ber . Monica	Drive			10f. Zip Code	21222		10g. Citizen of W Unite		•
020	within 72 hours efter deeth with the Meryland ene. than "natural", or items 23a or 28a-1 show he Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☑ Widowed 4		12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Yeer or Dates:			as Decedent of H res, specify Cube	dispenic Origin? (Spen, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	14. Race Black Specify:	- America k, White, e	
21215-0020	e filed within 72 hours el Hygiene. I other than "natural", vent, the Madical Exi	Completed	(Specify Elementary/Second		ucation de <i>completed)</i> College (1-4or 5		(Give kii life. DC	nt's Usual Occup nd of work done O NOT use retired	during most of work d)	king	16b. Kind of Bus	iness/Ind	
ba	el Hygie d other	BeC	17. Fether's Name (F				пс	memaker		e (First, Middle	Maiden Sumame		
yla	should be nd Mentel merked o	70		ls Young							Lengral		
Baltimore, Maryland	C1 0 2 2	1	19a. Informant's Nam Deborah D	, ,	<i>ype, Print)</i> sq/Guardi			Address <i>(Str</i> eet Vashingt	and Number or Rui .on Ave.				Code) 21204 Maryland
ore,	es 1 end of Health I Itam 27 r other tr		20a. Method of Dispo	osition		20b. Place of	of Disposit	ion (Name of tory or other place		Date	20c. Location - C		
Ħ Ĭ	9 5 7		4 ☐ Donation 5	Other (Specify		Holly			dns. 2/10	0/2005	Middle	Rive	r, MD
Bal	permit. Per Departmen Important: any injury		21. Signature of June	don E	Keen		792	22 Wise	Funeral Ave. Du	ndalk, N	Maryland	212	
(S. 20.)	Physician /Medical Examiner		23a. Part1. Enter the shock, or heart Immediate Cause (Fdisease or condition resulting in death)		a. Card	line	ar	rhy th	ig, such as cardiac		rrest,		Approximate Interval Between Onset and Death
	p #	ner				Due to (or as a	conseque	ence on:				1	
68760,	The lew requires that the death certificete be executed ate has been signed by the ettending physician and page 2 should be deteched for use as the burial-trensit	edicai Examiner	Sequentially list conditions any, leading to immease. Enter Underly Ceuse (Disease or in that initiated events	jury	c	Due to (or es e							
Box 68	eath certifice ettending phy for use es th		resulting in death) La		d								
P.O. E	the ett	ysici	Part II. Other signific	ant conditions co	ntributing to death bu	it not resulting i	in the unde	erlying cause give	en in Part I.	23b. Did 1	tobacco use cont	ribute to	the cause of death?
	s that the	y Ph	144	perten	Sion					1 🗆	Yes 2□ No	3 Prob	ably 4 Unknown
Division of Vital Records,	ew requires thet the death cer es been signed by the ettendin 2 should be detached for use	Completed by Physician/M	<u>De</u>	ment	ia					24a. Was perfo	en autopsy rmed?	avai	re autopsy findings ilable prior to apletion of cause eath?
<u> </u>	cete he	Com								404	/95 2 D W	1 🗆	Yes 2□ No
\frac{1}{2}	sician certifi director	To Be	25. Was case referred examiner? 1 ☐ Yes 2 ☐ No.	/ 1	Hospital:	nt 2 ER/O	utnationt	3□ DOA Oth	26. Place of Death	-	ne) dence 6 ⊟Other	(6	
on of	or Attending Physician: efter death. Director: After this certification by the funeral director,	tion: T	27. Menner of Death 1 ☑Natural 2 ☐ Accident	5 Pending investigation	28a. Dete of Injur (Month, Dey	y 28b.	Time of Injury	28c. Injun World			now injury occurre		
Divis	s ofter deal	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injubulding, etc.	ry - At home, fa . (Specify)	arm, street	t, factory, office		281. Location (5 City or Tox	Street and Number m, State)	r or Rural	Route Number,
	To the Hospital or Attending Physician: The lew within 24 hours efter death. To the Funeral Director: After this certificete hes completely filled in by the funeral director, page 2	Medical (29a. Certifier 1 (Check only 2 one)	Certifying Phy Medical Exami	sician: To the best of iner: On the basis of and manner ste	examinetion an	e, death o	ccurred at the tim tigation, in my op	ne, date end place, pinion, death occurr	and due to the e	cause(s) and man date and place, ar	ner as sta id due to t	ited. the cause(s)
	Total Michigan	∑	29b. Signature and tit	le of certifier/	Guo,	mp		29c. License	9855	Z	29d. Date signed	(Month, D	ay, Yeer)
200	200		30: Name and eddres	nav M	ompleted cause of de	eth (Item 23e)	(Type, Pri	Raver	7 Block	1. B4	timone	. M	102/239
58	Sta Registr	re l	31. Date iled (Month,		32. R	r's Signeture		19					
	- T		. 4	4 66	THE SECOND			- CE2					

RJ		0-12		State of Maryland / Dep. 1 - For Amend Item 1&19a&Unpend Item 23a	artment of Health and M Pt II 27 per me Gr Rificate of Beath	lental Hygier 341 3-8-05	tas
		Physici	an	1. Decedent's Name (First, Middle, Last) SVIVIA DKDID		2. Date of Death	3. Time of Death
		/Medic Examin		4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital	4b. City, Town, or Location of Death Baltimore		4c. County of Death
2002		Funeral Director		5. Social Security Number 6. Sex 1 M 252 F 7. Age (In yrs. last birthday) 240 · 53 · 3784 1 M 252 F 246 Yrs.		8. Date of Birth (Month, Day, Yea	9. Birtholace (State or Foreign
A D		death with the Maryland ms 23s or 28e-f show r must be notified at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Le	ocation Itimore		10d. Inside City Limits 1
		with the 3s or 28s	I Direc	10e. Street and Number 1602 Bolton Street	10f. Zip Code 21217	10g. (Citizen of What Country?
90	99	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan cartment of Health and Mental Hygiene. ordanit: If time 27 is marked other then "naturel; or Items 23a or 28e-f show injury or other traumatic event, the Medical Examinating the notified at all injury or other traumatic event.	by Funeral Director		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: NIGENAL
Monday 2424E 000E	20-6121	within 72 hou ane. then "nature	Completed I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation skind of work done during most of work DO NOT use retired) HMS ANGLUST	ing	Kind of Business/Industry POVICIENT Bank
6 660	yiaria z	ould be filed a Mental Hygie arked other atic event, II	To Be Co	12th grade 4 years System (First, Middle, Last) Patrick OKOLO		e (First, Middle, Maid	
100	e, Mar	1 and 2 sho Health and tem 27 is m		Patrick Okolo Pulmort Rhoman Okolo Sister 1402 20a Method of Disposition 20b. Place of Dispo	osition (Name of	Baltimo	y or Town, State, Zip Code) MD 2/2/7 Location - City or Town, State
<u> </u>	baitimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra ance.		1 SABurial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	matory or other place)		TOWSON, MD
_				23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final Exsanguination Cor			
•		mysician /Medical Examiner		disease or condition resulting in death) a. And Anticoagulatic Due to (or as a consequence of):	on		
000	8/00,	icate be executed physician and s the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to minecially cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): Due to (or as a consequence of):			
	ρ X	certif	hysician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
, C	as, r	uires that signed b	by P	Part II. Other significant conditions contributing to death but not resulting in the c Status Post Tricuspid And Mitral Va	, ,	23e. Did tobacc 1 ☐ Yes	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
		The lav ate has page 2 :	Completed	Rheumatic Heart Disease		24a. Was an autopsy performed 1 Yes 2	
24,74,74	DIVISION OF VITAL RECORDS,	ing Physicien: ۲. After this certific funeral director,	To Be	25. Was case referred to medical examinar? 1 XYes 2 No 27. Manner of Death 1 XNatural 5 Pending (Month, Day Year) 2 Accident investigation	nt 3 DOA Other: 4 Nursing Ho	h (Check only one) me 5 Residence 28d. Describe how in	
1/6	DIVISI	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
		he Hospi n 24 hou he Funer sletely fills	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.			
		To the within 2 To the complet	Ä	29b. Signature and title of certifier 7 is Line Lah Ah	29c. License number OCME		Date signed <i>(Month, Day, Year)</i> bruary 2, 2005
				30. Name and address of person who completed cause of death (Item 23a) (Type Z + RS(U L C + H + L)		Baltimore	, Maryland 21201
		Sta Regista		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

DHMH 17 Rev 1/2001

ORIGINAL

	•	For State Registrar	State of Maryland / Dep	partment of Health and Nertificate of Death		ene .n2005 0392
		1. Decedent's Name (First, Middle, Las	0		2 Date of Death	2 Time of Death
Physician		Lorayne S.	0wens		February	04 2005 5:30 P
/Medica Examine		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death Pasadena		4c. County of Death Anne Arundel
		5. Social Security Number 6. Se			9 Date of Righ	
Funeral Director			☐ M 2 ☐ F 85 Yrs.	Months Days Hours Min.	8. Date of Birth Month, Day Sept. 04	9. Birthplace (State or Fore County) Minnesota
land		10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Lim
8a-f sh	octor	Maryland Anne A	rundel	Pasadena		1 ☐ Yes 2 💢
23s or 2	al Dir	10e. Street and Number 1801 Wharf Cree	< Court	10f. Zip Code 21122	10g	i. Citizen of What Country? USA
permit. Pages 1 and 2 should be tiled within 72 hours atter deeth with the Maryland Depertment of Heatth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic svent, Ite Medical Evantral natural be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
hin 72 ho e. en "natur Medical	pleted	15. Decedent's Ed (Specify only highest gra	ucation 16a. Dec (Giv College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	sing 16	b. Kind of Business/Industry
giene arth	Ö	Elementary/Secondary (0-12)		Secretary		US Airforce
should be tiled and Mental Hygic marked other umatic svent, I	To Be (17. Father's Name (First, Middle, Last) Unknown	Stillwell		e (First, Middle, Ma Unknown	iden Surname)
2 sho and I is ma		19a. Informant's Name/Relationship (7	ype, Print) 19b. Mai	ling Address (Street and Number or Rui	ral Route Number, C	City or Town, State, Zip Code)
alth alth 27 i		Elaine Stroshane	(daughter) 180	1 Wharf Creek Cour	t. Pasade	na. MD 21122
other other		20a. Method of Disposition	20b. Place of Disp	position (Name of	Date 20	c. Location - City or Town, State
Page ent c nt: if ry or		1 ☐ Burial 2 ☒ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		ematory or other place) Feb. ematory Inc. 720	08 Ba	Itimore, Maryland
permit. Departm Importa any inju		21. Signature of Funeral Sample Licen		22. Name and Address of Facility 3111 Mountain Roa	Stallin	gs Funeral Home, P
eath certificate be executed Ex attending physician and tor use as the buriat-transit to use as the buriat-transit.	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	ne the av	200	Onset and Death
The law requires that the death certifica te has been signed by the attending phage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
uires that the de signed by the a lid be detached t	Completed by Pl	Part II. Other significant conditions o	ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death? 2 1 No 3 Probably 4 Unknow
w requir been s should	ete	DOLO a AM	11/2/2		24a. Was an	24h Were autoney findings avails
The law ate has page 2 s	d m	DOD T	7 7 9000		autopsy	d?/ 24b. Were autopsy findings available prior to completion of cause death?
10 CT (all soil	if disease			No 1 ☐ Yes 2 ☐ Mo
Physician: this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital:	Othor	h (Check only one)	
Phys this ral dii	2	1 Yes 2 No	1 ☐ Inpatient 2 ☐ ER/Outpatie	BILL 3 DOA 4 Nursing Ho	ome 5 esidence 28d. Describe how	ce 6 Other (Specify)
Attending F r death. actor: After by the funera	atlon	1	(Month, Day Year) Injury	Mork? Mork? M 1 Tyes 2 No	200. Describe now	injuly occurred
al or Atl	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this cartific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my knowledge, dealiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the caus red at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
To th To th	Me	29b. Signature and title of certifier	(O alge	29c. License number $D3/3221$		Date signed (Month, Day, Year)
1		30. Name and address of person who	completed cause of death (Item 23a) (Type 4304)	p. Print)	7D PAS.	4DEAM, OLD 2112
1		31. Date filed (Month, Day, Year)	32. Restrar's Signature	100111101 VOX	+ 1 1 1 2 1	10000

			- State Amend Item 19	State of Maryland / Da a-b per fh G840 2	epartment of Health and Certificate of Death	d Mental Hygie Reg.	ne 005 03929
	Physici	200	1. Decedent's Name (First, Middle, Last)	Partine		2. Date of Death	Day Year 3. Time of Death
	Physici /Medic	al .	4a. Facility Name (If not institution, give s	read and number)	4b. City, Town, or Location of Do	FEBRUARY	Day Year 0725 M 4c. County of Death
	Examin	er	ST- AGN (S 1405)		BATIMOR	1	NIA
	Funeral Director		5. Social Security Number 6. Sex 126-54-7538		Months Days Hours M	Hrs. 8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country) WEW YORK
	/land	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town			10d. Inside City Limits
	the Marylar 28e-f ehow	ctor	MD NA	Balti	more		1 TYes 2 No
	ath with th	Funeral Director	200 S. Hiltor	1 St.	10f. Zip Code 2/29	(Citizen of What Country?
215-0036	togs 1 and 2 should be filed within 72 hours after deeth with the Maryland nt of Heatih and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28e-f ehow or other traumatic event, the Medical Evantural must be notified at	þ	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pt 1 ☐ Yes 2 Pro Specify: 	(Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
5-0	"natu	letec	15. Decedent's Edu (Specify only highest grade	completed) (Decedent's Usual Occupation Give kind of work done during most of life. DO NOT use retired)	working 16b	b. Kind of Business/Industry
212	I within liane.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) Adv	. , , , , , , , , , , , , , , , , , , ,	sistant S	tate of mo
	al Hyg	BeC	17. Father's Name (First, Middle, Last)		18. Mother's	Name (First, Middle, Maid	
Maryland	should be filed within 72 hours nd Mental Hygiene. marked other then "natural; ; imatic event, the Medical Exa	ဥ	19a. Informant's Name/Rela ionship (Ty	na Reint) 10hai	Dark	3001 -0	ames
	1 and 2 sho fealth and em 27 is m		Chane Payne da	ush rerother 5	27°Storr St., Bar	to. Md2122	ity or Town, State, Zip Code)
Baltimore,	of Hea of Hea fitem r othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	20b. Place of I	Disposition (Name of , crematory or other place)	Date 200	. Location - City or Town, State
tim	Fag filment flent: i		*4 □ Donation 5 □ Other (Specify)	Interro	Crematory 2-	8-05 W	atonsville, mb
Bal	permit Pages Department of P Importent: If its any ir jury or of		21. Signature of Meral Service Limit		Gary P. March Fl		nilton Pass Baltomb
1	Pnysician /Medical Examiner		23a. Part. Enter the disease, or complishock or heart failure. List only or Immediate Cause (Final	cations that caused the death. Do not not cause on each line.		diac or respiratory arrest,	Approximate Interval Between Onset and Death
			disease o condition resulting in death)	Due to (or as a consequence of			UNKNOWN
			Sequentially list conditions,	septic sh	ock		1 week
	ted nsit	Examiner	flary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to [o] as a consaquence of	utosi's		1 1 1 h h n u m
o,	rate be executed thysician end the burial-transit	Exal	resulting in death) Last	Due to (or as a consequence of			unknown
68760,	icate be execul physician end the burial-trar	dicai		SLE			unknown.
Box	ath certific ttending p or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ②No 9 □ Unknown	3c. If yes, outcome of pregnancy 1	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
, P.O	res that the de signed by the a l be detached f	by Ph	Part II. Other significant conditions cor	ntributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
ords	w raquire baen sig should b					1 ☐ Yes	2 No 3 Probably 4 Unknown
Division of Vital Records,	The law ate has b	Completed				24a. Was an autopsy performed	
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:	Other	Death (Check only one)	
ō	ding Phys h. After this funeral di	n: To	1,20 Yes 2 □ No 27. Manner of Death	28a. Date of Injury 28b. Ti	me of 28c. Injury at	g Home 5 ☐ Residence 28d. Describe how i	
ion	Attending r death. actor: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) In	M 1 Yes 2 No		
Divis	tel or Attors after de si Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fam building, etc. (Specify)	π, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, itate)
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical			death occurred at the time, date and p for investigation, in my opinion, death o		
)	To t To t	Σ	29b. Signature and title of certifier	MD	29c. License number P 1861 C		Date signed (Month, Day, Year)
/	7-11		30. Name and address of person who co				, , , , , , , , , , , , , , , , , , ,
	U '		31. Date filed (Month, Day, Year)	JON AVE, Bald	imore MP 212	4	
	Sta Regist		FFR 0	3 2005 Meners	Type, Print) Timore MD 212		

PASNE

J			1 - For Amend Item 1 St Registrar	ate of Maryland r me G840 2-	1 / Depa -22-05 <i>Cer</i>	artment of H	lealth and M Death	1ental Hy	giene	2005	03930	
	Physici /Medic		Decedent's Name (First, Middle, Last)	lip Eugene I				2. Date of Do Month Februa	eath Day		3. Time of Death 04:57 A.	
	Examir		4a. Facility Name (If not institution, give stree: Mercy Hospital	and number)		4b. City, Town, or Baltin	Location of Death	TOBLA	_	County of Death		
	Funeral Director		5. Social Security Number 6. Sex 128 06 3333 128M	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bi	ay, Year)	9. Birth	place (State or Foreign ntry)	
	land bw		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation		inag. c	,0,1		10d. Inside City Limits	
	Marylan e-f show	ctor	Maryland N/A	Ва	ltimo	re					1 X Yes 2 ☐ No	
	with the e or 28 be no	Director	10e. Street and Number			10f. Zip Code	0.0			zen of What Cou	ntry?	
9	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I then "neturel", or Items 23e or 28e-1 show other treumatic event, the Medical Examinat must be notified at	/ Funeral	1 XNever Married 2 Married 1	UE /as Decedent Ever in U.S. med Forces? □Yes 2 XNo Yes, Give	11	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Spin, Mexican, Puerto	ecify Yes or N Rican, etc.)		U.S. 14. Race - Americ Black, White, Specify: Wh:	etc.	
9	hours:	ed by		ear or Dates:		ent's Usual Occup			16h Kir			
21215-0036	thin 72 e. an "ne	Completed	(Specify only highest grade con	oilege (1-4or 5+)	(Give lite. L	kind of work done o OO NOT use retired	during most of work	ing		nd of Business/In	ŕ	
121	e filed with al Hygiene. I other ther vent, Itte N		10th 17. Father's Name (First, Middle, Last)		Labo	rer	18. Mother's Name	/Eirat Middle		oving Cor	npany	
land	ould be f Mental H Larked of	To Be		ene Parker,	Sr.			issa K		Sumame)		
Maryland	and 2 should leath and Men n 27 is marke		19a. Informant's Name/Relationship (Type, F Melissa Rodriguez	. *		g Address (Street a	and Number or Rura Avenue				and 21230	
Baltimore,			20a. Method of Disposition 1 □ 3Burial 2 □ Cremation 3 □ Remov	con	ce of Dispos netery, crem	sition (Name of natory or other plac	(e:	Date		cation - City or To		
time	Pant Ind		* 4 □ Donation 5 □ Other (Specify) 21. Signal 4 of Juneral Service (A) en sel			ll Cemete				imore, 1		
Ba	permit. Departm Importe any inju		21. Signal and of Juneral Service intensee	ridge	4	Name and Addres	ss of Facility Go lie Highwa			Service	e, P.A. yland 21225	
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the death. use on each line.						sic, nai	Approximate Interval Between	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Strangulation a. Strangulation									
			Due to (or as a consequence of):									
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
,	cate be executed oblysician and the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
8760,	cate be physicia the bur	dicai	d									
9	eath certific attending p I for use as 1	/Mec	IF FEMALE: 23b. Was decedent pregnant 23c. if	yes, outcome of pregnance						23d. Date of delive		
). Box	ed for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	□Live birth 2 □Fetal d □Pregnant at time of dea □Unknown		Ectopic pregnancy Other (specify)				Month	Day Year	
P.0	that the de ted by the a detached		9 ☐ Unknown Part II. Other significant conditions contribut		ing in the un	deriving cause give	en in Part I.	23e. Did	tobacco us	se contribute to th	he cause of death?	
Vital Records,	The law requires that the death certifii te has been signed by the attending I age 2 should be detached for use as	ed by						1 🗆		V.	pably 4 Unknown	
Reco	has be ge 2 sh	Completed						24a. Was		prior to con	psy findings available mpletion of cause of	
tal	10 -	a	25. Was case referred to medical				26. Place of Death	1 XYes	2 🗆 No	death? 1 Z Yes	2□ No	
of V	Physicien: this certific al director,	To B	examiner? 1 XYes 2 No Hospit	1 Inpatient 2. LE	R/Outpatient	3□ DOA Othe	ar.			i □Other (Specifi	y)	
Division o	ding J. After fune	Certification;	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	8b. Time of Injury,	28c. Injury Work 1□	Yes 2 No	28d. Describe SUGJ		occurred Strangl	ed	
Jivis	or Attendate death Director:	rtific	3 ☐ Suicide 6 ☐ Could not be determined 28	e. Place of Injury - At hom building, etc. (Specify)				City or To	wn, State)	Number of Rura	I Route Number,	
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by		29a. Certifier 1 Certifying Physician	Division of C	edge, death	occurred at the tim	e, date and place,	ind due to the	cause(s)	AND MANDER AS ST	Dated	
	the Ho	Medical	one) 2 2 Medical Examiner: (In the basis of examination and manner stated.	n and/or inv	estigation, in my op	pinion, death occurr	ed at the time,	date and	place, and due to	the cause(s)	
)	To You	_	29b. Signature and title of certifier Auch Hal	laund		29c. License				signed (Month, s		
	P		30. Name and address of person who comple			Print)	Street Ba	ltimore				
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	гө			- 02111011	, ±1Cl.	Lyzuiu Z	1401	
Dist	Registr	- 4	FEB 0 9 200	Been	H.	Court		27.50				
DHI	MH 17 Rev 1/20	JU I			RIGINA							

			1 - For State Registrar	State of M	aryland / De	partmen ertificat			ind Me		ienę _{eg. Nó.}	05	039	131			
	Physici		1. Decedent's Name (First, Middle, La Margaret W. Pit							Date of Deal Month January)05 05	3. Time of 2:45				
	/Medic Examin		4a. Facility Name (If not institution, gi Ginger Cove He	r	4b. City, Town, or Location of Death Annapolis					4c. County	4c. County of Death Anne Arundel						
	Funeral Director		100-16-0876	Sex 7. Ag 1 ☐ M 2 [X] F	e (In yrs. last birtho	Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day, Feb 12,	^{Year)} 1917	9. Birthp Cour Mary	olece (State o htry) land	r Foreign			
	e-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Anne A	rundel	10c. City, Town o	Location						1	0d. Inside Ci				
	h with the	al Director	10e. Street and Number 4000 River Cresc	ent Drive		10f. Zip		1401		1	0g. Citizen of V USA	What Cour	ntry?				
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Evanti at must be realthed an once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 \(\subseteq Yes \) 2 \(\subseteq Yes \) Give Year or Dates:		3. Was Dece If Yes, spe 1 \(\subseteq Yes		spanic Orig n, Mexican, Specify:	gin? (Speci , Puerto Ri	ify Yes or No- can, etc.)	Blac	e - Americ ck, White,					
	vithin 72 hounder	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) I 2		(6	ecedent's Usu ive kind of wo e. DO NOT u	rk done d se retired)	uring most	of working	,	16b. Kind of Br		dustry				
nd 2	al Hygie d other t		Be Co	17. Father's Name (First, Middle, Las	t)		homen		18. Mother			Maiden Suman	home				
ıryla	should but marked	ဥ	Robert Presto		-	ailing Address	(Street a			toria H Route <i>Number</i>	orn , City or Town,	State, Zip	Code)				
Baltimore, Maryland 21215-0036	and 2 lealth a m 27 Is her tret		Victoria Allan/d	laughter	30 20b. Place of D			n Roa	d Anr	napolis	•	1403	01-1				
	L. Pages I tment of P tent: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Spec	ify)	cemetery,	crematory or c	ther place				20c. Location -						
Bal	permii Depar Impor any ir once.		21. Sign ure of uneral Struce Lice Kon 3 d S	Wade, Dir	eter	State Baltim	Anato	omy Bo MD 2	bard 21201	655 W.	Baltim	ore S	treet				
	Pnysician /Medical Examiner		resulting in death) Due to (or as a consequence of):								respiratory arre	est,		Approximate Interval Bety Onset and I	veen		
8760,	icate be executed physician and sthe burial-transit	ıi Examiner	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of)												
9	rtificate h ng physi as the b	Medicai	IF FEMALE:	d													
.O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Completed by Physician/Me	þ	by	by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	in the past 12 months? 1 Yes 2 No No No No No No No No No No					Ectopic pregnancy Other (specify)				23d. Date of delivery Month Day Year	
<u>α</u>	w requires that been signed b should be deta					by	by	by	by	Part II. Other significant conditions Arthrufu O.	contributing to death to	out not resulting in th	g in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of o	
al Records,				/						24a. Was an autops perform	y ned?	prior to con death?	psy findings ampletion of ca				
fVital	Physicien: The this certificate had director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	Hospital:	ent 2 ER/Outpa	tient 3 DC	Othe			Check only one 5 Reside	e) ince 6 🗆 Oth	er (Specif	y)	-			
Division of	ding I			Certification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	he -	y Year) Inju	M M		at ? ′es 2 □ N	10		w injury occurr				
DIVI	itel or At rs after c el Direc led in by	Certif	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							City or Town	reet and Numb , State)	er or Hura	HOUIB NUMI	oer,			
	To the Hospitel or Attanding within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	(Check only one) 2 Medicel Exe	hysician: To the best miner: On the basis o and manner st	f avamination and/o	r investigation	in marray	inion dooth	h agained	as sha sima ala	sta and slaga .	and dies to	46				
)	To vit	~	29b. Signature and title of certifier	Μλ		29	0.0000	595	-8	2	1/27	105	Day, rear)				
			30. Name and address of person who	completed cause of	leathy(Item 23a) (Ty	pe, Print)	nno	files	, l	of d	# 106	Od	entoni	-21113 YID			
: ~	Sta Registr		31. Date(file) (Month, Day, Year) (FEB	9 2005 Regis	ar's Signature	Apa	W'						-				

			Plea.	ase Type or P State of				Ensure All Health and Me	-	_	ble.	
			1 - State Registrar			Ce	rtificate of	Death	Re	eg. No.	D 500	
	Physici /Medic		Decedent's Name (First, Midd JOHN FREDE		ER, SI	₹.			2. Date of Deat Month	Day	Year 830 P M	
	Examir			n, give street and numbers. Hospit		inter	Rosi	e dale		4c. County Ba	of Death Itimore	
	Funeral Director		5. Social Security Number 218-01-3121	6. Sex 1 🖾 M 2 🗆 F	. Age (In yrs.	86 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 4–24–	Year) -1918	Birthplace (State or Foreign Country) MARYLAND	
altimore, Maryland 21215-0036	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD BA	, LTIMORE	10c. City, Town or Locati			ROSEDALE			10d. Inside City Limits 1 ☐ Yes 2 🛂 No	
	n with the 3a or 28a st be noti	Funeral Director	10e. Street and Number 8111 SUMTER AVENUE			10f. Zip Code 2123	7	1	0g. Citizen of V	What Country?		
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, the feath of items 23s or 28s-f show item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, it a Madical Evartical must be notilised at	by	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 M Ses 2 No If Yes, Give Year or Dates:			I.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or No- f Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:				e - American Indian, ck, White, etc. :: WHITE	
	within 72 ho iene. than natu	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed) College (1-	4or 5+)	(Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired) NAL SERVICEMANAGER				. Kind of Business/Industry NU TONE	
	ould be filed we Mental Hygis warked other fatic event, It	To Be C	17. Father's Name (First, Middle, CHARLES A.	Last) PFEI	FER	<u> </u>		18. Mother's Name (First, Middle, Maid			den Sumame) DESCHLER)	
	and 2 should be ealth and Mental n 27 is marked i er traumatic ev	_	19a. Informant's Name/Relations DORIS PFEIFER)		and Number or Rural VENUE ROSE			State, Zip Code) 21237	
	Pages 1 and 3 nent of Health int: If item 27 iry or other tr.		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (3		tate = C	cemetery, cre	osition (Name of matory or other pla	сө)			City or Town, State	
Balt	permit. Pages : Department of H Important: # ite any injury or ot once.		21. Signature of Funeral Service	Licensee	2			ss of Facility CVAC SACO AVENUE		DALE FUN SEDAIE,	NERAL HOME MD 21237	
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	t only one cause on ea	used the deat ch line.	5	ter the mode of dyii	ng, such as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death	
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	b. Due to (o	r as a conseq	quence of):						
3760,	ate be executed hysician and the burial-transit	licai Examine	resulting in death) Last Due to (or as a consequence of):									
P.O. Box 687	that the death certificate be ed by the attending physici detached for use as the bu	Physician/Medica	nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Feta ntattime of d	at death 3	□Ectopic pregnanc □ Other (specify) _	y		23d. Dat	e of delivery nth Day Year
	es be	by	Part II. Other significant conditi		ith but not res	•		ren in Part I.		oacco use contr	ribute to the cause of death?	
l Reco	0 4 0	Completed			· 	· · · · · · · · · · · · · · · · · · ·			24a. Was ar autops perform	y ned?	Nere autopsy findings available prior to completion of cause of feath? Yes 2 \(\subseteq \text{No} \)	
/ita	lysician: The sister of the contificate director, pag	Be (25. Was case referred to medica examiner?				Lau	26. Place of Death				
n of	Phys this al di	Comparison Com										
Division of Vital Records,	or Attendifter deatl	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Str. City or Town)								er or Rural Route Number,	
	ne Hospitel 24 hours a ne Funeral I	edical C	29a. Certifier (Check only one) Certifyi 2 Medical	ng Physician: To the base and many	is of examina	owledge, deat ation and/or in	th occurred at the tid evestigation, in my d	me, date and place, ar opinion, death occurred	nd due to the ca d at the time, da	ause(s) and ma ato and place, a	nner as stated. and due to the cause(s)	
1	To the within 2 To the complet	N 2/	29b. Signature and title of certific	- YIII	ist	M.	29c. Licens	5 8 67 1	29	9d. Date signed	(Month, Day, Year)	
2	2-10-		30. Name and address of person						iore	Marylo	and 21237	
	Sta		31. Date filed (Month, Day, Year		gistrar's Signa	ature						

Physici		 Decedent's Name (First, Mide 	dle, Last)							2. Date of De		,	3. Time of	Death
/Medi		Richard Lee F	oseno							FEBRUAI	RY 5,	, 2005	2:07A	
Examir		4a. Facility Name (If not instituti	on, give street and nu	mber)		4b. City,	Town, or	Location of	of Death			County of Dea	ath	
		UPPER CHESAPEA				BI If Under	ELAII	R If Under	04 Hrs	0.0	1	ARFORD		
Funeral Director		5. Social Security Number 220-92-2992	6. Sex 1 ☐ M 2 ☐ F	40	. last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bit (Month, Da 12-12-1	y, Year)		rthplace (State of country) yland	r Fore
		Usual Residence of Decedent								12 12 1		Har	yrand	
urylan show		MD Balt	•		ity, Town or Lo	ocation							10d. Inside C	-
the Marylan r 28a-f show	Scto		imore	Arı	butus								1 □ Yes	2 3
with t	吉	10e. Street and Number 1262 Maple Av	e			10f. Zip	Code 21227	7			-	izen of What C	Country?	
filed within 72 hours after death with the Maryland Hygiene. ythar than "natural", or Items 23a or 28a-f show ant, the Madical Examinat must be multified at	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U	U.S. 13.				gin? (Sp	ecify Yes or No Rican, etc.)		14. Race - Am	erican Indian,	
or ite	균	1 ☑ Never Married 2 ☐ Ma		2 ☑ No	ĺ	If Yes, spec 1 ☐ Yes 2				Rican, etc.)	1	Black, Wh		
raf', c	db	3 Widowed 4 Divorce	od If Yes, Gir Year or D	ve ates:		1 Yes 2	24E1 NO	Specify:				Specify: W	nice	
"natural",	Completed	15. Decede (Specify only high	nt's Education est grade completed)		16a. Dece	dent's Usua kind of wor DO NOT us	al Occupa rk done d	ation Juring mos	t of work	ing	16b, Ki	nd of Busines:	s/Industry	
withir ene. than	d L	Elementary/Secondary (0-12)	College (1-4or 5+)		and					A +	omobil.		
should be filed within Ind Mental Hygiene. s markad othar than umatic evant, the Mental Menta	Be Co	17. Father's Name (First, Middle	, Last)		Doug	and	rend		er's Name	e (First, Middle		omobile Sumame)	2	
should be nd Mental markad c	To B	Roger Lee Pos	eno					Lois	Mar	ie Pose	no			
2 should and N is mail	[-]	19a. Informant's Name/Relation	nship (Type, Print)		19b. Maili	ng Address				al Route Numb		r Town, State,	Zip Code)	
is 1 and 2 should of Health and Men itam 27 is marka othar traumatic		Lois Marie Po	seno/ Moth					. Arl		s, MD 2	1227			
		20a. Method of Disposition 1 ☐ Burial 2√ Cremation	3 □Removal from		Place of Dispo cemetery, cre-	osition (Nam matory or ot	ne of ther place	9)		Date	20c. Lo	cation - City o	r Town, State	
tment tant:		`4 ☐ Donation 5 ☐ Other (Specify)	Bay	yview C		-	,		0-2005	Balt:	imore,	MD	
permit. Page Department i Important: If any injury or once.		21. Signatule of Funer Service	Dense Line		A A	a. Name and Simbros	d Addres e Fu	s of Facilit neral	y L Ḥor	ne, Inc				
		23a. Part1. Enter the disease,	or complications that of	aused the dea								us, MD	21227 Approximate	
Examiner			Due to	(or as a conse	quence of):		оста	ICTOII	WIC	h Aspir	atio	n or 11	ic racen	
executed an and rrial-transit	Examiner	Sequentially list curditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to	(or as a consector as	quence of):		оста	ICTOIL	WIT	n Aspir	at10	n ot 11	ic race.	
I the death certificate be executed by the attending physician and ached for use as the burial-transit	edical Examin	that initiated events	Due to c Due to d 23c. If yes, ou 1□Live b	(or as a consection of pregnish 2 ☐ Fet lant at time of	quence of): quence of): nancy al death 3 [⊒Ectopic pre	egnancy	ICION	Witi	n Aspir		OX III	alivery	'ear
equires that the death certificate be executed en signed by the attending physician and ould be detached for use as the burlal-transit	Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) No	Due to c	(or as a consection of pregneral at time of own	quence of): quence of): nancy al death 3 [death 5 [□Ectopic pre	egnancy ecify)				obacco u	23d. Date of de Month	alivery	eath?
The law requires that the death certificate ale has been signed by the attending physoge 2 should be detached for use as the	Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to c	(or as a consection of pregneral at time of own	quence of): quence of): nancy al death 3 [death 5 [□Ectopic pre	egnancy ecify)			23e. Did t	obacco u Yes 2 ^d	23d. Date of de Month se contribute t	Day h	ear
The law requires that the death certificate ale has been signed by the attending physoge 2 should be detached for use as the	Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condit Cocaine Use 25. Was case referred to medic examiner?	Due to c	(or as a consection as a consection of pregning to the consection of pregning to the consection of th	quence of): quence of): nancy al death 3 [death 5 [sulting in the u	□Ectopic pre □ Other (spe	egnancy ecify)ause give	en in Part I. 26. Place	of Death	23e. Did to 1 24a. Was autoperficity Yes	obacco u Yes 2th an psy yrmed? 2 \(\text{No} \)	23d. Date of de Month Se contribute to Se contribute to Se contribute to Se contribute to Se contribute to Se contribute to Se contribute to Se contribute to Se contribute to Se contribute to Se contribute to Se contrib	Day h	ear
The law requires that the death certificate ale has been signed by the attending physoge 2 should be detached for use as the	To Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c	(or as a consection as a consection of pregration and at time of own leath but not resonant at time of own leath but not resonant at time of own leath but not resonant at time of leath but not resonant at time	quence of): quence of): quence of): ancy al death 3E death 5E sulting in the u	□Ectopic pre □ Other (spe Inderlying ca	egnancy ecify) ause give	on in Part I. 26. Place	of Death	23e. Did t	obacco u Yes 2 d an psy ormed? 2 \(\text{No} \)	23d. Date of de Month se contribute to No 3 P 24b. Were a prior to death?	Day h	ear
The law requires that the death certificate ale has been signed by the attending physoge 2 should be detached for use as the	To Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c	(or as a consection as a consection of pregnion 2 ☐ Fet nant at time of own eath but not related to the consection of injury 1, Day Year)	quence of): quence of): nancy al death 3 [death 5 [sulting in the u	□Ectopic pre □ Other (spe Inderlying ca	egnancy ecify) ause give	on in Part I. 26. Place	of Death	23e. Did to 1 24a. Was auto performent of Check only of the control of the contro	obacco u Yes 2 d an psy ormed? 2 \(\text{No} \)	23d. Date of de Month se contribute to No 3 P 24b. Were a prior to death?	o the cause of deposits of the cause of deposits of the cause of deposits of the cause of deposits of the cause of deposits of the cause of deposits of the cause of deposits of the cause	ear
ttending Physician: The law requires that the death certificate death. Totalh. Total this certificate has been signed by the attending physithe funeral director, page 2 should be detached for use as the	To Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c	(or as a consection of pregners) to the section of pregners and at time of own eath but not resident to the section of Injury (a), Day Year) 15	quence of): quence of): quence of): quence of): quence of): ancy al death 3 [death 5 [sulting in the u 28b. Time of Forme of 1:38	Ectopic production of the second of the seco	egnancy ecify) ause give ause give 8c. Injury Work 1 Y	26. Place	of Death	23e. Did to the control of the contr	an psy primed? 2 No one) dence 6 how injury	23d. Date of de Month Se contribute to the Month of the	o the cause of derobably 4 \(\subseteq \) utopsy findings a completion of circles 2 \(\subseteq \) No	ear nkno vailai uuse (
or Attending Physician: The law requires that the death certificate sifer death. Director: After this certificate has been signed by the attending physin by the funeral director, page 2 should be detached for use as the	o Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condit Cocaine Use 25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend inves 2 Accident 3 Suicide 6 Coulc	Due to c	(or as a consection as a cons	quence of): quence of): quence of): quence of): quence of): ancy al death 3 [death 5 [sulting in the u 28b. Time of Forme of 1:38	Ectopic production of the second of the seco	egnancy ecify) ause give ause give 8c. Injury Work 1 Y	26. Place	of Death	23e. Did to the control of the contr	obacco universal de la composición del composición de la composición del composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición	23d. Date of de Month se contribute to Solution (Special Control Cont	o the cause of deposits of the cause of deposits of the cause of deposits of the cause of deposits of the cause of deposits of the cause of deposits of the cause of deposits of the cause	ear nkno vailai uuse (
dospital or Attending Physician: The law requires that the death certificate # hours after death. *unaral Director: After this certificate has been signed by the attending physen process in by the funeral director, page 2 should be detached for use as the	Certification: To Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c	(or as a consection as a conse	quence of): quence of): quence of): quence of): quence of): ancy al death 3 [death 5 [sulting in the u 28b. Time of format 1:38 nome, farm, strify) owledge, deat	Ectopic production of the second of the seco	egnancy ecify) ause give 8c. Injury Work 1 Y	26. Place or: 4 \(\text{Nu} \) at ? (es 2 \(\frac{\frig}\frac{\figmi\f{\f{\f{\frac}\firac{\f{\frac{\fir}}}}}}{\f	of Death	23e. Did t 1 24a. Was autopent 12 Yes 1 (Check only of the check on the check on the check only of the check on the check on the check o	an psy 2 long long long long long long long long	23d. Date of de Month se contribute to the Month 24b. Were a prior to death? 3 Other (Spectred)	blivery Day to the cause of deprobably 4 U utopsy findings a completion of cause of the caus	ear eath? nknov vailala use c
dospital or Attending Physician: The law requires that the death certificate # hours after death. *unaral Director: After this certificate has been signed by the attending physen process in by the funeral director, page 2 should be detached for use as the	Certification: To Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c	(or as a consection as a conse	quence of): quence of): quence of): quence of): quence of): ancy al death 3 [death 5 [sulting in the u 28b. Time of format 1:38 nome, farm, strify) owledge, deat	Dectopic production of the control of the coursed a vestigation,	egnancy ecify) ause give Bc. Injury Work 1 Y	26. Place in: 4 □ Nu at ? (es 2 🏋	of Death	23e. Did t 1 24a. Was auto; perfc 12 Yes 1 (Check only of the control of the co	an psy primed? 2 No pone) dence 6 how injury. Street anawar, State) 1, Md cause(s) date and	23d. Date of de Month se contribute to the Month of the	o the cause of deprobably 4 United Maple s stated.	ear eath? nknov vailai uuse c
or Attending Physician: The law requires that the death certificate sifer death. Director: After this certificate has been signed by the attending physin by the funeral director, page 2 should be detached for use as the	To Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c	(or as a consection as a conse	quence of): quence of): quence of): quence of): quence of): ancy al death 3 [death 5 [sulting in the u 28b. Time of format 1:38 nome, farm, strify) owledge, deat	Dectopic production of the control of the coursed a vestigation,	egnancy ecify) ause give ause give Nork 1 Y office at the tim in my op	26. Place or: 4 \(\text{Nu} \) at at at an inion, deal inumber	of Death	23e. Did to the deat the time,	obacco unity of the state of th	23d. Date of de Month se contribute to prior to death? 24b. Were a prior to death? 27b. The Control of the C	o the cause of deposition of cause of deposition of cause of deposition of cause of deposition of cause of the cause of th	ear eath? nknov vailala use c
dospital or Attending Physician: The law requires that the death certificate # hours after death. *unaral Director: After this certificate has been signed by the attending physen process in by the funeral director, page 2 should be detached for use as the	Certification: To Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c	(or as a consection of pregnish 2 February 1 and at time of own eath but not restricted by the consection of Injury 1, Day Year) 105 106 107 107 108 108 109 109 109 109 109 109 109 109 109 109	quence of): quenc	Dectopic prince of the control of the course	egnancy ecify) ause give ause give Nork 1 Y office at the tim in my op	26. Place in: 4 □ Nu at ? (es 2 🏋	of Death	23e. Did to the deat the time,	obacco unity of the state of th	23d. Date of de Month se contribute to the Month of the	o the cause of deposition of cause of deposition of cause of deposition of cause of deposition of cause of the cause of th	ear eath? nknov vailate use c
dospital or Attending Physician: The law requires that the death certificate # hours after death. *unaral Director: After this certificate has been signed by the attending physen process in by the funeral director, page 2 should be detached for use as the	Certification: To Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c	(or as a consection as a consection of pregnish 2 February 1 and at time of own eath but not related to finjury 1, Day Year) 15 15 16 16 17 18 18 18 18 18 18 18 18 18 18 18 18 18	quence of): quenc	Dectopic print of the course o	egnancy ecify) ause give 8c. Injury Work 1 1 Y c, office at the tim in my op License O.C.	26. Place 26. Place 17. 4 □ Nu at ? e, date an- inion, deat number , M.E.	o of Death rsing Hor No	23e. Did t 1 24a. Was autopent. 24a. Was autopent. 24b. Check only of the second of t	yes 25 an psy primed? 2 No pone) dence 6 how injury. Street and cause(s) date and 29d. Date	23d. Date of de Month se contribute t No 3 P 24b. Were a prior to death? 10 Ye 3 Other (Spectrost) 2507 Real and manner a place, and du e signed (Monta)	o the cause of deposition of cause of deposition of cause of deposition of cause of deposition of cause of the cause of th	ear eath? nknov vailai uuse c

		1 - For State Registrar	State of M	larylan		artmen <i>rtificat</i>				lental Hy	gien		03934
Physici /Medio		1. Decedent's Name (First, Middle, La Tempie Irene Pu	sloskie							2. Date of De Month Februar	Da	y Year 2005	3. Time of Death
Examir	ner	4a. Facility Name (If not institution, gives Stella Maris at M	ercy Medical			Balti	more	Location of				. County of Death	
Funeral Director		5. Social Security Number 6. S 234-56-6250 Usual Residence of Decedent	M 2DF	ge (in yrs. i	last birthday) Yrs.	Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da Jan.21,	y, Year)	/ Cou	place (State or Foreig intry) Virginia
e Marylan 3e-f show	ctor	MD 10b. County			y, Town or Lo timore	ocation							10d. Inside City Limits
ath with th	Funeral Director	10e. Street and Number 4205 Bayonne Avenue				10f. Zip	Code 21206				10g. Ci	U.S.A.	intry?
and 21215-0036 be filed within 72 hours after death with the Maryland ntal rtyglene. bd other than "netural", or ttems 23a or 28e-f show event, the Medical Examinar must be multified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 Yes 2, If Yes, Give X Year or Dates:	? No		1 ☐ Yes	2 X No	Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	•	14. Race - Ameri Black, White Specify:	, etc.
Maryland 21215-0036 id 2 should be filed within 72 hours at the and Mental hylgiene. Its marked other than "netural", or traumatic event, the Medical Exami	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation de completed) College (1-4or	5+)	life. L	dent's Usua kind of wor DO NOT us witch	rk done d se retired)	u <i>ri</i> ng most		ng		ind of Business/Ir	ndustry
ed tal	To Be C	17. Father's Name (First, Middle, Last) Lawrence Shrewsbury						18. Mothe	r's Name rene	Griss, Middle,	Maiden	Sumame)	
P, Mar and 2 sho lealth and m 27 Is m her traum		Mr. Paul Pusloskie -			4205 E	Bayonne	e Aver	nd Numbe nue B	altim	ore, Mary	er, City o	or Town, State, Zij 21206	o Code)
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke eny injury or other traumatic. once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specification)	1)	CE	lace of Disposemetery, crem	natory`or of ervice	corp.	. 2,	/12/0	ate 5		ocation - City or T on, Mary la	
Balt permit. Departr Importe eny inju		21. Signature of Funeral Service Licer 23a. Part1. Enter the disease, or company the part of the disease, or company the part of the part	near tries			. Name and	larfor	d Road	d Bali	onard J. timore, N	arv1	, Inc. and 21214	
/Medical Examiner	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as C. Due to (or as	a consequ	ence of):		=11		he				Approximate Interval Between Onset and Death
the death certificate be by the attending physicial ached for use as the burner ached for the	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 confits? 1 □ Yes 2 □ No 9 □ Unknown	d	of pregnan 2 Fetal t time of de	ncy death 3 ath 5	Ectopic pre Other (spe	ecify)				2	23d. Date of delive Month	ery Day Year
he law requires that has been signed age 2 should be del	by	Part II. Other significant conditions of	ontributing to death b	out not resul	lting in the un	derlying ca	iuse giver	in Part I.			bacco u es 2[_	ne cause of death? pably 4 Unknown
_ b at	Completed									24a. Was a autop perfor 1 Yes	sγ	prior to condeath?	psy findings available impletion of cause of
ding Phys After this funeral di	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Da		ER/Outpatient 28b. Time of Injury		Other	: 4 □ Nurs	sing Hom	(Check only or ne 5 ☐ Resid 8d. Describe h	ence 6	6 Other (Specify occurred	n hospice
LIVISION To the Hospitel or Attending within 24 hours after death To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, et	ury - At hon c. (Specify)	ne, farm, stre	et, factory,	office		2	8f. Location (S City or Tow	treet and n, State)	d Number or Rura)	l Route Number,
To the Hospitel within 24 hours a To the Funeral I completely filled	fedical	one)	rsician: To the best iner: On the basis of and manner sta	i examinatio	rledge, death on and/or inve	occurred a estigation, i	t the time in my opi	, date and nion, death	place, ai	nd due to the c d at the time, d	ause(s) late and	and manner as st place, and due to	ated. the cause(s)
To with To con	Σ	29b. Signature and title of certifier	X ~			1	License			2	Pd. Date	e signed (Month,	
15		30. Name and address of person who de 10c, Vi D RISENSEN	301 5	I Par	of Pi		Him	ore	no	d 2	120	2	
Stat Registra	3.1	31. Date filed (Month, Day, Year) FFR 6 9 200	32. Registra	ar's Signatu	ire								

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			ato of Marylana, D	Certificate of D	eath	Reg. No. 2005	1 03030
	Physician /Medical	1. Decedent's Name (First, Middle, Last) OVOTO 4a Fecility Neme (If not institution, give street	laine Par	•	2. Dete of De Month FChruz	Vy 4 200	3. Time of Death 9
	Examiner	Roland Park Place 5. Social Security Number 6. Sex	7. Age (In yrs. lest birth	Bandey) If Under 1 Year	altimore City If Under 24 Hrs. 8. Date of Bi	N/A	plece (State or Foreign
	Funeral Director	212-30-3178 Usuel Residence of Decedent	Λ / /4	rs. Months Days	Hours Min. (Month, D. January	16, 1931 Mary	Tand
	vith the Marylan or 28a-f show be notified at Director	Maryland N/A	10c. City, Town Baltimon	re City			10d. Inside City Limits 1 1 Yes 2 □ No
	a 23a or 2 nut be n	1512 Kennewick Road		10f. Zip Code 21218		10g. Citizen of What Cou USA	
980	72 hours after death with the Maryland natural; or itema 23a or 28a-f show idical Examiner must be notified at eted by Funeral Director	1 Never Married 2 Married	/as Decedent Ever in U,S. rmed Forces? Yes 2 No Yes, Give eer or Dates:	13. Was Decedent of Hist If Yes, specify Cuben, 1 ☐ Yes 2 ☑ No	penic Origin? (Specify Yes or No Mexican, Puerto Rican, etc.) Specify:	14. Race - Amer Black, White Specify: Whit	, etc.
Baltimore, Maryland 21215-0036		15. Decedent's Education (Specify only highest grede com Elementary/Secondary (0-12) Co	ollege (1-4or 5+)	Decedent's Usual Occupati (Give kind of work done du life. DO NOT use retired) Cretary	on ring most of working	16b. Kind of Business/li Bank	ndustry
pur	d off H	17. Father's Neme (First, Middle, Last)		1	8. Mother's Name (First, Middle	•	
Lyla	d 2 should be it and Mental it is marked or traumatic eve	Joseph Paul 19a. Informant's Name/Relationship (Type, P.	trint) 19b.		nne Florence Koste		in Code)
Ma	カモトラ	Virginia Crouse-Friend			ve Middletown, MD		,
imore,	of of the part of	20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Remov 4 □ Donation 5 □ Other (Specify)	val from State Hilltop	Disposition (Name of crematory or other place) Service Corp.	2/8/05	20c. Location - City or T Towson Marylar	
Balt	permit. Peg Department Important: I any Injury o once.	21. Signature of Funeral Service Licensee ()	ristina L. Hilton	22. Name and oddruss Legnar 1 5305 Harrioru	of Fecility Ck. Inc. Road Saltimore Ma	ryland 21214	
		23a. Pert1. Enter the diseese, or complication shock, or heart failure. List only one cau	ns that caused the death. Do no use on each line.	ot enter the mode of dying,	such as cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)	refasfatie Due to (or as e co		acer		onegear
60,	that the death certificate be executed ed by the attending physician and datached for use as the burial-transit y Physician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	Due to (or es e co	onsequence of):			
Box 68760,	eath certificete be attending physicia i for usa as the bur clan/Medical i	that initieted events resulting in death) Last	Due to (or as e co	onsequence of):		1	
O. E	at the death ce d by the attendi atached for us.	Part II. Other significant conditions contributi		4		tobacco uee contribute	
<u>α</u>	as that tha de igned by the a be datached i	Chronic starty	uctive lua	g disea	se 10	Ýee 2⊡No 3⊡Pro	obably 4 Unknown
of Vital Records,	iw requir			<i>V</i>		ormed?	Vere autopsy findings vailable prior to ompletion of cause f death?
al	Iclan: The is certificate ha rector, paga a	25. Was case referred to medical					☐Yes 2☐No
Ξ	W	examiner? 1 Yes 2 No Hospit	al: 1 ☐ Inpatient 2 ☐ ER/Out	Other	26. Place of Death (Check only		ify)
Division o	After fune fune	2 ☐ Accident investigation	e. Date of Injury (Month, Dey Year)	jury Work?	et 28d. Describe	how injury occurred	
Dixi	To the Hospital or Attend within 24 hours after deet To the Funeral Director; completely filled in by the Medical Certificat	4 Homicide	e. Place of Injury - At home, fare building, etc. (Specify)		City or To		
	To the Hospital of within 24 hours a To the Funeral D Completaly filled	(Check only 2 Medical Examiner: C	 To the best of my knowledge, on the basis of exemination end and menner steted. 				
	To the To the Comp	29b. Signature end title of certifier	The Orana	29c. License r		29d. Date signed (Month)	
•	10	30. Name and address of person who complete	ted cause of deeth (Item 23e) (1	Type, Print)		February	TIDEUS
	Cinto	31. Date filed (Month, Day, Year)	EGOR, 830W. L	tomsikeet)	OND WIRE)	- 2 2 2 11	
	State Begistrar	FEB 0 9 2005	32 registrer's-Signature	Dogwell)		*	

DHMH 16 Rev 6/95

ORIGINAL

Keith Smith 05-00926 DOS

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

0926		State of Maryland / Department of Maryland / D	artment of Health and M rtificate of Death	Mental Hygien 0 0 5	03936
Physici	an	1. Decedent's Name (First, Middle, Last) Keith Smith		2. Date of Death Month Day Year	1.4
/Medio Examin		4a. Facility Name (If not institution, give street and number) Sinai Hospital	4b. City, Town, or Location of Death	February 5, 2005 4c. County of Dec	133Z p
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Bi	rthplace (State or Foreign
Director		217. 96. 6112 19M 2 F 24 Yrs. Usual Residence of Decedent	None Days House	03.20.1980	MD
Marylan f show	tor	10a. State 10b. County N/A 10c. City, Town or Lo			10d. Inside City Limits 1 ☑Yes 2 ☐ No
with the	Direc	10e. Street and Number 1925 Wallbrook Avenue	10f. Zip Code	10g. Citizen of What C	Country?
ems 23	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- 14. Race - Am	
ours afte	þ	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify:	Black
hin 72 ho s. in "natu Mevical	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)		
filed with Hygiene Ather the		10th grade N/A 17. Father's Name (First, Middle, Last)	Laborer 18. Mother's Name	e (First, Middle, Maiden Sumame)	caping
ould be I Mental parked c	To Be	Keith Smith, Sr.		Hc Gamer	2.77
and 2 sh lath and 27 Is m er traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailli 192	ng Address (Street and Number or Rure 5 Walbrook Ale	nue Batto. MD	
ages 1		20a. Method of Disposition 1	material attendance	Date 20c. Location - City of Pandalls!	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23e or 28a-f show any injury or other traumatic event. The Madical Extratilier is ast the mullified at ODCe.			2. Name and Address of Facility Corcens Fund ST BUILDING NATION		
		23a. Part1. Ent. + the disease, or complications that caused the death. Po not ent shock, or heart failure. List only one cause on each line.			Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	UT WOUND	OF MEAD	Onset and Death
Examiner	7	Sequentially list conditions.			
be executed sician and burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c.			
The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dical E	Due to (or as a consequence of):			
leath certifica attending ph I for use as th	n/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of d	elivery
at the death by the atte	Physician/Me	in the past 12 months?	□Ectopic pregnancy □ Other (specify)	Month	Day Year
res that t igned by be detar	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death? Probably 4 □Unknown
aw require is been sig 2 should b	Completed			24a. Was an 24b. Were a	autopsy findings available b completion of cause of
	e Com	25. Was case referred to medical		performed? death?	s 2 No
ys Gilb	To B	examiner? 1 XYes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	nt 3 DOA Other: 4 Nursing Ho	h (Check only one) ome 5 □ Residence 6 □ Other (Sp	ecify)
anding Fath. or: After he funer	atlon		of 28c. Injury at Work? O M 1	28d. Describe how injury occurred	AS SHOT
el or Att s after de il Direct id in by t	Certification:	3 Suicide 6 Could not be determined 28e. Place Injury - At home, farm, stress building, etc. (Specify)	FWAZK	28f. Location (Street and Number or F City or Town, State) 297 Aufe RA(7) 297	Rural Route Number,
To the Hospitel or Attending Ph Within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of Examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause(s) and manner a red at the time, date and place, and du	as stated. ue to the cause(s)
To the within To the	Me	29b. Signature aper title of certifier	29c. License number OCME	29d. Date signed (Mor February 6	
3		30. Name and address of person who completed cause of death (figm 23a) (Type,	Print)		
Sta	ate	31. Date filed (Month, Day, Year) FFR 0 9 2005	VVI	Baltimore MD 212	·OT
Regist		FEB 0 9 2005 Blance D. April			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 Physician 5, A^{M} Feb. 4:20 Soule /Medical 4a. Facility Name (If not institution, give street and number) 7504 Hackamore Dr. Examiner 4b. City, Town, or Location of Death 4c. County of Death Potomac Montgomery 5. Social Security Number 579.40.1698 Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1(XM 2□F 88 Director Yre 15,1916 Dec. Washington DC Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits traumatic event, the Medical Exercitive must be notified at MD Director Montgomery Potomac 1 √ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7504 Hackamore Dr. Items 23a 20854 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, parmit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" —" any injury or other traumatic average. Black, White, etc. 1 ☐ Never Married 2 1 Married 1 ☐ Yes 2 🗓 No Specify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 4+ Officer U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Floyd Soule 2 Lula Weston Allison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Soule / Son 7504 Hackamore Dr., Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ^ 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery Feb. 8,2005 21. Signature of Funeral Service Licenses 22. Name and Address of Facility oseph Gawlers Sons Inc. 5130 Wisconsin Ave. N.W., Washington DC 20016 23a. Part 1. Enter the disease, of some shock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Parkinson's Disease Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law raquires that the death certificate be axecuted use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 ☐ Other (specify) P.O. 1 9 Unknown 9 Unknown signed t I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Be Completed 1 ☐ Yes 2 🗓 No 3 Probably 4 □Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2**X** No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide 24 hours a Funeral L 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) within 2 To the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D39456 02/05/05 0 30. Name and a fress of person who completed cause of death (Item 23a) (Type, Print) Lila T. McConnell, 5530 Wisconsin Ave., Chevy Chase, MD 31. Date filed (Month, Day, Year) FEB 0 9 2005 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

					State of M	aryiai		epartifica Certifica				ieillai Hy	Reg. No.	05	03	938
			1. Decedent's Name	e (First, Middle, Last)							2. Date of D		Year	3. Time	e of Death
	Physicia /Medic	al :		Seymour								Jan.	31, 2005	5	11:	30pm
	Examin		4a Facility Name (If)			1			ocation of Dea				
			18131 S1a 5. Social Security No	ade School		ge (In yrs.	last high	if Und	1	Sand	-		Prince			to or Foreign
	Funeral Director		577.42.95	532 10	M 21XF	94		Month:			Min.	8. Date of B (Month, D July	ay, Year) 14,1910			te or Foreign
	how tel		Usual Residence of 10a. State	10b. County			•	or Location				•		1		e City Limits
	8a-fs	Director		Prince Ge	eorges	Sar	ndy S	Springs					.212			es Z No
	with th	吉	10e. Street and Num						ip Code				10g. Citizen of			
	s 23	era	18131 S1a	ade School	L RD 12. Was Decedent	Ever in U	.s.		0860 edent <i>o</i> f I	Hispanic Or	riain? (Sp	ecify Yes or N	United	State ce - Americ		
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other trsumatic event, the Medical Examinar must be notified at once.	by Funerai		ed 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	?				an, Mexica Specify		ecify Yes or N Rican, etc.)		ck, White,		
2-0	72 ho	e ed	(Speci	15. Decedent's Edu ify only highest grad	cation e completed)		16a. [Decedent's Us 'Give kind of v life. DO NOT	ual Occup	oation during mos	st of work	ing	16b. Kind of B	usiness/In	dustry	
Maryland 21215-0020	d within giena. r than	Completed by	Elementary/Secon		College (1-4or	5+)		<i>life. DO NOT</i> ntal A:					Dental	Offi	ce	
pu	al Hyg	Bec	17. Father's Name (First, Middle, Last)								,	e, Maiden Surnar	ne)		
yla	ould b Ment arkec	2	James W.							J			Heath			
Mar	12 sh hand rism trsum			me/Relationship (Ty	rpe, Print)			_					ber, City or Town 0854	State, Zip	Code)	
ē,	1 and Haalt em 2	-	Sam Seymo			20b. F	Place of [Pettit Disposition (N	ame of		omac,	Date	20c. Location	- City or To	own, State)
ШO	Pages ant of nt: If it ry or o			XCremation 3 □F 5 □ Other (Specify)		Mo	unt	, crematory of Comfor	t Cre	ce) emato:	ry 2	2/7/05	Alexand	lria,	VA	
Baltimore,	permit. Departm Importa any inju	ŀ	21. Signature of Fur	neral Service Licens	ee			22. Name 5 130	and Addre	ess of Facil	ityJose Ave	ph Gaw	lers So	ıs In	с.	
_	20 E 8 9		Vany	din		378		Washi	ngtor	n DC	2001	16				
ı			23a. Part1. Enter the shock, or hear	e disease or compl t failure. List only or	ications that cause ne cause on each I	d the deat ine.	th. Do no	ot enter the m	ode of dyi	ng, such as	s cardiac	or respiratory a	arrest,	i	Approxin Interval E Onset ar	nate Between nd Death
1	Physician /Medical		Immediate Cause (I	Final	Sect	Υ -	. \	Nales	الما	~						
	Examiner		disease or condition resulting in death)	1	Seps.			onsequence of		.600						
	p #	ner		3 <u>25</u> 1					,-					} 		
_	rificata ba axecutad ng physician and as tha burial-transit	edicai Examiner	Sequentially list cor if any, leading to im	nditions, mediate	J	Due to fo	ras a co	เกระตุนะกระ ป) .							
68760,	a ba a /sician a buris	caiE	Sequentially list conif any, leading to im cause. Enter Under Cause (Disease or i that initiated events	rlying injury	o	Due to (o	rasa co	nsequence of):					-		
	= 5, 0	Medi	resulting in death) L	Last	d				,							
Вох	aath cer attandir I for usa	sian														
P.O.	as that tha daath cer ignad by the attandir be datached for usa	Physician/M	Part II. Other signifi		1	1		the underlying	cause gi	ven in Part	I.		I tobacco use co I Yea 2 □ No			
	ss that gnad b	by P	Advanced	Semle	demer	1410	•									
Records,	requir	eted	Emphyse	m2.									s an autopsy ormed?	av.	ailable prid	
	0 - 50	Completed	Concocti	ve Heart	Failu	50						1 🗆	Yes 25 No		death? ⊒Yes 2	2∄No
ital	icisn: The certificata rector, pag	BeC	25. Was case referr examiner?	ed to medical						26. Plac	e of Deat	h (Check only	one)			
× ×	hysic his ce al dire	2	1 ☐ Yes 2 🗷 1	No	lospital: 1 ☐ Inpati				JUA				idence 6 Doth		y)	
Division of Vital	ding P. h. After t	Certification:	27. Manner of Death	5 ☐ Pending investigation	28a. Date of Inju (Month, Da	ury u <i>y Year)</i>	28b. Tir Inj	me of ury M	28c. Inju Wo	ryat rk?]Yes 2.⊡		28d. Describe	how injury occur	red		
Visio	Attence r daatl	ifical	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of In	jury - At h	ome, farr						(Street and Numi	ber or Rura	il Route N	lumber,
Ö	ital or irs afta ral Dire	Cert	4 Homicide		building, et											
	To the Hospital or Attending Physicisn: within 24 hours after death. To the Funeral Director: After this certific completaly filled in by the funeral director,	edicai	29a. Certifier (Check only one)	1⊠ Certifying Phys 2□ Medical Exami		f examina										.e(s)
	To th withir To th comp	Me	29b. Signature and	title of certifier	~					se number			29d. Date signe	d (Month,	Day, Year	7)
			1	E HOWE	CM				D33	700			February	3,	2005	5
	7	-		ess of person who co	ompleted cause of	death (Iter			1.1.	1.0.0	- 40	441	72179	_		
	U		31. Date filed (Month		32. Registr	rar's Signa		ST. U	CULIF	tonsA) (('	MID	2119	>	~	
	Sta Registr		31. Date filed (Mont	EB 0'9 2	005	love	D.	Coas								

Funeral

Director

item 27 is marked other than "natural", or Itams 23a or 286-f show other traumatic event. Its Medical Examinar must be notified at

Hygiene.

2 should be f and Mental I

permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun 2002.

/Medical

Airiam Stockbridge

Proviction Examiner Records, P.O. Box 68760 Division of Vital

burial-transit attending physician the as After Hospitel or Attending death. within 24 hours after death

To the Funeral Director:
completely filled in by the

Registrar

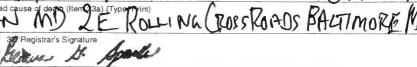
Medical

29a. Certifier (Check only one)

FEB 0 9 2005

Name and address of person who

29b. Signa ure and title of certifier



Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month Dey, Year)

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of I rtificate of		-	giene 0	05	03940
	Physici	an	1. Decedent's Name (First, Middle, Las	STEUEL	IC			2. Date of De	Day	Year	3. Time of Death
	/Media		4a. Facility Name (If not institution, give		luter	4b. City, Town, o	or Location of Deat	FEB	4c. County		7.00 1
	Funeral Director		5. Social Security Number 6. S 219 12 5707	FRM OFF	(In yrs. last birthday, Yrs.	If Under 1 Year Months Days			iy, Year)	9. Birthpi Coun Mar	ace (State or Foreign try) yland
	a-f show	ctor	10a. State 10b. County Maryland Anne A		10c. City, Town or L Baltimo					11	0d. Inside City Limits 1 ☐ Yes 2 🔀 No
	3a or 28	I Dire	10e. Street and Number 102 Camrose Ave	nue		10f. Zip Code 212	225		10g. Citizen of V		try?
900	perrait. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other treumetic event, I're Medical Examinar must be naitlied at ance.	d by Funeral Director	11. Marital Status 1 □ Never Married 2⊠ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🖾 No		Specify Yes or No to Rican, etc.)	Specify	e - Americ ck, White, e y: Whi	etc.
21215-0036	d within 72 h glene. ir then "natu	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 8th	ducation de completed) College (1-4or 5+	(Give	dent's Usual Occup kind of work done DO NOT use retire Lice Offi	during most of wo		Balto.		
Maryland	12 should be filed within n and Mental Hyglene. Fis marked other then "reumetic event, Ire Mass	To Be C	17. Father's Name (First, Middle, Last) James S	tevens			Ма	me (First, Middle ry Kirms	se		
	and 2 sh salth and n 27 is n		19a. Informant's Name/Relationship (· · ·		ng Address (Street Camrose A		ural Route Numb Baltimor			
Baltimore,	Pages 1 ament of He ent: If iten ury or oth		20a. Method of Disposition 1			osition (Name of matory or other pla en Mem.]		Date 10/2005	20c. Location -	-	m, State Maryland
Balt	permit. Dep rtr Imports any inje		21. Signature of Funeral Service Licar	see Anlicaei		2. Name and Addre	ess of Facility G nie Highw	once Fur vay Ba			, P.A. /land 21225
8760,	Physician /Medical Examiner physician and physician and the prival the prival the physician and the p	dicai Examiner	23a. Part. Enter the disease of com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter 'Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a c. C.	privato bonsequence of): 2 cut to consequence of):		umon	là	rrest,		Approximate Interval Between Onset and Death I (I Cuy)
P.O. Box 68	ath certific ittending p or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregnanc	у			te of deliver	y Day Year
	quires that the de n signed by the a uld be detached f	ρ	Part II. Other significant conditions c	ontributing to death but	not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did t			e cause of death?
al Records,	siclen: The law requir certificate has been si irector, page 2 should	e Completed	Of Wo					1 ☐ Yes	osy med?	prior to com death?	sy findings available ipletion of cause of
of Vital	Physiclen: this certific ral director,	To Be	25. Was case referred to medicat examiner? 1 \(\text{Yes} \) 2 \(\text{MS} \)	Hospital:	t 2 ER/Outpatie	nt 3 DOA Ott		ath <i>Check on c</i> lome 5 ☐ Resid		er (Specify,	
ion	After After fune	ation:	27. Manner of Jeath Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wor	ryat rk? Yes 2 □ No	28d. Describe I	how injury occurr	red	
Division of	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (3 City or Tox	Street and Numb wn, State)	er or Rural	Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of niner: On the basis of e and manner state	examination and/or in	h occurred at the til vestigation, in my o	me, date and place ppinion, death occu	e, and due to the irred at the time,	cause(s) and ma date and place,	inner as sta and due to	ited. the cause(s)
	*	M	29b. Signature and title of certifier	MIL)	29c. Licens	6399		29d. Date signed		ay, Year)
	σ_{j}		30. Name and address of person who Dr. Jeanette Na:		ath (Item 23a) (Type,	,	Baltin	more, Ma	ruland (21202	
I	Sta Registi		31. Date filed (Month, Day, Year)	9 2005 Registr	s Signature	Sports	-31011		-yranu z	21202	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death February 03 **Physician** 2005 Doris Saunders 12:50 PM June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Anne Arundel medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | NOV | 12 Year | 924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🂢 F 80 Yrs. Director 491-26-8052 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "natural", or Items 23e or 28e-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Anne Arundel Pasadena Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 606 Eliot Road 21122 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Household 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be McDaniel Clava Varlev Veree Schell Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) mit. Pages 1 and 2 st artment of Health and crtent: If item 27 is n 606 Eliot Road, Pasadena, MD 21122 George A. Saunders (spouse) other 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State pern it. Pag Dep. riment Imp. rient: I any injury o Memphis, Missouri Memphis Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 2/12/05 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the hease, or com shock, or heart failure. List only of that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician (Gnce Un disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Die to (or as a consequence or) any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-transit The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Physician/Medical SE FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4☐Pregnant at time of death Day 5 ☐ Other (specify) ۾ certificate has been signed t rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 🗆 Ng 1 Tes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death Director: 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only within 2 29b. Signature and title of pertifier 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 32. Figistrar's Signature Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	_		1 - For State Registrar	State of M		partment of leartificate of		Mental Hygier		03942
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, WALTER P. 4a. Facility Name (If not institution,	SOMP	AYRAC	4b. City, Town,	or Location of Death	Hebruary	Day Year 200.	3. Time of Death 5 12:30 p, M
	Funeral Director	·		BILITATION EX 6. Sex 7. A 1 XM 2 F	TENDED CARE Age (In yrs. last birthda 62 Yrs.		BALTI If Under 24 Hrs.	8. Date of Birth	N/A	
	the Maryland 28a-1 show	ector		ltimore	10c. City, Town or	Hale:	thorpe			10d. Inside City Limits 1 ☐ Yes 2☐ No
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Evanting runtified at	d by Funeral Director	10e. Street and Number 1814 Park Avenu 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceden Armed Forces	¹ 861	10f. Zip Code 2. 3. Was Decedent of If Yes, specify Cub 1□ Yes 2∏ No		Ţ	United St 14. Race - Ame Black, White Specify: V	tates
2121	12 should be filed within 72 h h and Mental Hygiene. 7 Is marked other than "natu traumatic event, the Medical	Be Completed by	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, L	College (1-4or	r 5+) (Gi	cedent's Usual Occu ve kind of work done DO NOT use retire Carpente	during most of work 2 T 18. Mother's Nam	ne (First, Middle, Maide	Kind of Business/ Construen Sumame)	,
re, Maryland	es 1 and 2 should of Health and Mer f item 27 Is marke r other traumatic	To	Walter Alexande 19a. Informant's Name/Relationsh Walter A. Sompa 20a. Method of Disposition	ip <i>(Type, Print)</i> yrac Fathe	19b. Ma er 1814 20b. Place of Dis	4 Park Ave	enue, Hale	ral Route Number, City		
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr QDG8.		1 & Burial 2 Cremation 4 Docation 5 Other (Sp	ecity) ICENSES LO LO LO LO LO LO LO LO LO L	Memori:	1328 Sulpt	2-4-2 ess of FacilitAmb nur Spring	rose Funera g kd., Arbu		Inc.
	Physician /Medical Examiner		23a. Pan1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. HETAS T	ed the death. Do not eline, TIC CLL s a consequence of):		ng, such as cardiac			Approximate Interval Between Onset and Death M VN WS
8760,	sate be executed shysician and the burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of):					
.O. Box 6	The law requires that the death certificate be executed tie has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	BEctopic pregnanc	у		23d. Date of deli Month	very Day Year
Records, P.	w requires that been signed b should be deta	by	Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cause gr	ven in Part I.	1 ☐ Yes	2 No 3 Pro	
Vital Rec		Be Completed	25. Was case referred to medical examiner?				26. Place of Deat	24a. Was an autopsy performed? 1 Yes 2 X	prior to c death?	topsy findings available completion of cause of
Division of V	this ral dii	Certification; To I	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigs 3 Suicide 6 Could no	ation		of 28c. Inju. Wo		ome 5 Residence 28d. Describe how inj	ury occurred	
Divi	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		4 Homicide determine 29a. Certifying	building, e	njury - At home, farm, stc. (Specify) t of my knowledge, de	ath occurred at the ti	me, date and place,	28f. Location (Street a City or Town, Sta and due to the cause((s) and manner as	stated
).	To the He within 24 To the Fu completel	Medical	(Check only 2 Medical E	xaminer: On the basis of and manner's	or examination and/or stated.	29c. Licens			nd place, and due late signed (Manth	
6	Sta	te	30. Name and address of person w AURU (CA 31. Date filed (Month, Day, Year)	the completed cause of TAN 39	00 LUCH	Print) PAVEN	BOULEVA	RD, BAL	TI MORE	MD 21218
	Registr		EED O Q	2005	va St. A.	care				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 10:39 AM Cassidy Alyssa Smith 2005 TINN 30 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death BALTIMORE AGNES HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 F ,30,2005 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Baltimore Arbutus 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 5915 Oakland Rd 21227 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/AN/A 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Charles Walter Smith III Amy M. Rites 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles Smith III/ Father 5915 Oakland Rd. Arbutus, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 2-11-05 Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD 21227 21. Signature of Funeral Service License Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ABRUPTIO PLACETA resulting in death) PREMATURITY EXTREME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dus to for as a consequence of resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery 3 ☐ Ectopic pregnancy 1 Live birth 2 ☐ Fetel dea 4 Pregnant at time of death 2 | Fetel death Year Month Day 5 Other (specify) 9 Unknown 30 2005 TAN 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 2 **N**O 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 211 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ∰ No

Priysician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

MD

Directo

Funeral

Completed by

Be

item 27 is marked other than "natural", or items 23s or 28s-f sho other traumatic event, the Martical Exercities must be notified at

I Hygiene.

nent of Health and Mental Hy nt: if item 27 is marked othe 'y or other trainman'

permit. Page Department of Important: If any injury or

filed within 72 hours after death

Maryland 21215-0036

Baltimore,

Vital

of

Division

death.

after

hours To the Funeral

24 within

Director:

Examiner and signed by the attending physician d be detached for use as the buria has page 2 certificate completely filled in by the funeral After

Physician/Medical Completed Be 2 Certification;

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

5 Pending

investigation

1 ■ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

D25 393

🗿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 30, 2005

21228

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CALVERTON ST BALTIMORE MD KH 707 MD

31. Date filed (Month, Day, Year) 32. Registrar Signature 2005

State Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Dete of Deeth 3. Time of Death **Physician** Year thevine 6:10 pm bruary 2005 /Medical 5 Fecility Neme (If not institution, give street end number) 4b_City, Town, or 4c. County of Death cation of Deeth Examiner romwel NIA Under 24 Hrs. Age (In yrs. lest birthdey) If Under 1 Year Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Deys Hours Min Director 214-26-5410 Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours eftar deeth with the Marylend Depertment of Heelth end Mentel Hygiene. Important: if tem 27 is marked other than "naturel" or harm not any injury or other trainment. 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMONE PARKUILLE 1 ☐ Yes 2 ☐ No MD Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21234. U.S.A PALMA Funeral 1. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes 2☑No Specify: Completed by Specify: 3 Widowed 4 Divorced WhiTe 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12+2 SAles ART CORP NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be tre Rerick Unknown 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Pellicot PALMA MARY CATLERING CT Balto. MS 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State → Burial 2 Cremation 3 Removal from State 2/9/05 4 ☐ Donation 5 ☐ Other (Specify) BAITO. MS BALTIMORE cem 22. Name and Address of Fecility
HARTLEY MillER - STELLA FUNERAL HURE CHTD. 21. Sonature of Funeral Service Licenses harford Both MS RO. 7527 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner ba axecuted bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last end Dus to (or as a consequence of) Box 68760, attending physiclen for use es the burial Physician/Medical Due to (or as a consequence of): P.0. bean signed by the a should be detached Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 dunknown 1 ☐ Yes 2 ☐ No of Vital Records, Completed by Heart Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has certificate 2 3-No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: ٩ Other: 2016 1 Yes 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this fillad in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Division To the Hospital or Attending 1 Natural 5 Pending investigation 1 Yes 2 🗆 No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number DOOS985 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) 900 5601 Loch Kaven

DHMH 16 Rev 6/95

State Registrar

31. Date-filed (Month, Day, Year)

32. Registrer's Signature

2005

		1 - For State Registrar	State of Maryla			of H		•		2005	03945
Physic /Medi	cal	1. Decedent's Name (First, Middle, Last, Beatrice Evel	yn	Smith				2. Date of Month Feb	5,	2005	3. Time of Death 7:15A M
Examir Funeral Director		4a. Facility Name (If not institution, give Frederick Villa 5. Social Security Number 6. Security Number 15. Security Number 16. Security Number 15. Security Number	Nursing Hom	e s. last birthday) Yrs.		Cato	Location of Dea nsville If Under 24 Hr Hours Mir	S. 8. Date of I	Birth Day, Year)	Baltin 9. Birth Cou	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygeine. Importent: If item 27 is marked other than "netural; or Items 23a or 28a-1 show appring or other traumatic event, Ital Medical Examinating the motified at ance.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore 10e. Street and Number 408 D. Shade Tr 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 11 17. Father's Name (First, Middle, Last) John Henry Whi 19a. Informant's Name/Relationship (Ty Dana Harmon Gra 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	ree Trace 12. Was Decedent Ever in Amed Forces? 1	19b. Mailing 19 Place of Disponentary, creating 22	was Decediff Yes, spec I of. Zip Was Decediff Yes, spec I Yes 2 dent's Usual kind of wond DO NOT us. I tivit Ing Address I ttst I tts Ceiton (Namatory or ot. Its Ceit Name and	2122 ent of His ify Cubar I Occupal k done di k done di k done di c e retired) y As (Street au on C e of ther place mete	panic Origin? (, Mexican, Pue Specify: ion st. 18. Mother's Na Stell ad Number or F ircle) iry 2/8	ame (First, Midde a Flow Rural Route Num Owings Date /05 11824 R	Fred Fred Fred Fred Mills, Maiden ers Mills 20c. Lc Rei eiste	U.S.A. 14. Race - Amening Black, White, Specify: wind of Business/Ir erick Vificumame) r Town, State, Zij man 21 cation - City or T sterstow	can Indian, etc. White industry Llla N.H. D Code) Ll7 Own, State
death certificate be executed death certificate be executed e attending physician and of for use as the burial-transit	lical Examiner	23a. Part 1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate dates. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a conse	quence of):				ac or respiratory			Approximate Interval Between Onset and Death
at the death certifice by the attending phatached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fel 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pre Other (spe				-	23d. Date of deliv Month	ery Day Year
aw requires that is been signed 2 should be de	Completed by Ph	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	nderlying ca	use giver	n in Part I.	1 [24a. Wi	Yes 2	No 3 Prot	he cause of death? pably 4 Donknown posy findings available impletion of cause of
Attending Physicien: The death. ector: After this certificate by the funeral director, pag	Certification; To Be Cor	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Accident investigation 3 Suicide 6 Could not be determined	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Spec	28b. Time of Injury	M 28	Other Bc. Injury: Work?	4 Nursing	1 Yes eath (Check only Home 5 Re 28d. Describ	2 No v one) sidence e how injur	d Number or Rura	
To the Hospitel or within 24 hours after To the Funerel Direct Completely filled in 1	Medical Co	29a. Certifier (Check only 2 → Medical Examinate) 29b. Signature and title of certifier Control Co		ation and/or in	vestigation,	License	nion, death occ	curred at the time	e, date and 29d. Dat	and manner as s place, and due to e signed (Month,	Day, Year)
Sta Registr		KOVEN L. Behing 31. Date filed (Month, Day, Year) FEB - 9 20	H, M.D. 25 A	rain S	weet,	SUI	te zon	Reista	ecspi	un, MD	2/136

Please Type or Print i	n Black Indelible Ink.	Ensure All Copies	Are Legible
			•

		1 - State Registrar		aryland / Dep <i>Ce</i>	rtificate of D		Reg	000	5 0391
Physici	an	Decedent's Name (First, Middle,					2. Date of Death Month	Day	Year 3. Time of De
/Medic		4a. Fecility Name (If not institution,	inna Maria	Slifker	4b. City, Town, or L	anation of Death	February		
Examin	ier	Stella Maris Hos						4c. County o	
uneral			. Sex 7. Ag	e (In yrs. last birthday)		If Under 24 Hrs.	8. Date of Birth	Ba⊥	timore Co. 9. Birthplace (State or Fo
irector		218-36-1291	1□M 2□xF	96 Yrs.	Months Days	Hours Min.	(Month, Day, Y Aug. 19		Country) Maryland
≯		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	postico				-
23e or 28a-f show	ō	,	ltimore	Too. Oity, Town of Et	ocation	Ess	OV		10d. Inside City L 1 ☐ Yes 2⁄4
28a-	Director	10e. Street and Number			10f. Zip Code			011	
3e or	<u></u>	617 Eastern	Arronna		Tol. Zip Gode	0.7.0		. Citizen of WI	
ms 2	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	212 panic Origin? (Spe			d States - American Indian,
el', or Items Evantiner m		1 Never Married 2 Married		10			Rican, etc.)	Black	White, etc.
En	d by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give A Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	White
"naturel"	Completed	15. Decedent's (Specify only highest of	Education grade completed)	16a. Dece	dent's Usual Occupation kind of work done during the control of t	on ing most of work	ina 16	b. Kind of Bus	iness/Industry
	mp	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	DO NOT use retired)	•	9		
를 는	ပိ	8 Years 17. Father's Name (First, Middle, La	et)	<u>F</u>	Iomemaker	0. 14-15-1-1-1-1	/F:	Own	
9 g) Be		,		18		e (First, Middle, Ma	•)
Is marked of raumatic ever	2	George S. Goe		19h Mailie	ag Addross (Street and		ena Dause		
27 ls r trau	14	Thomas Slifke			ng Address <i>(Street and</i> Deejay Dr				
othe		20a. Method of Disposition	7 7 5011	20b. Place of Dispo	sition (Name of				ryland 2104:
nt: If i		12 Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec		1	natory or other place)				•
Importent: If i eny injury or o once.	1	21. Signatur of Juneral Service Lic	• •		ph Church Name and Address		8/2005	Fuller	ton, Maryla
eny ir		A nadas	511.5	Du	da-Ruck Fu 122 Wise Av	neral Ho	ome of Du	ndalk,	Inc. 21222
physician and the burial-transit	Il Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Classes of Figury that initiated events resulting in death) Last	C	a consequence of):					
by the attending packached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	23c. If yes, outcome of the pregnant at the second of the	2 Fetal death 3 time of death 5	Ectopic pregnancy Other (specify)			23d. Date of Month	
e d p e d	by	Part II. Other significant conditions	contributing to death bu	t not resulting in the ur	iderlying cause given i	n Part I.	23e. Did tobace		ute to the cause of death Probably 4 X Unkn
ate has	Completed	25. Was case referred to medical					24a. Was an autopsy performed	? prio	re autopsy findings avail or to completion of cause th? Yes 2 \(\sumbole \text{No}\)
is certific director,	To Be	examiner?	Hospital:	nt 2 ER/Outpatien	Other		(Check only one) ne 5 ☐ Residence	6 19 Oah	(Caraital HOGDY)
Affer th funeral		27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Time of	28c. Injury at Work?		28d. Describe how in		(Specify) HOSPIC
Funerel Director: tely filled in by the	Certification;	3 Suicide 6 Could not determined		ry - At home, farm, stre (Specify)	eet, factory, office	2	28f. Location (Street City or Town, St		or Rural Route Number.
ately fil-	edical	29a. Certifier Madical Execution Check only one Certifying P	hysician: To the best of miner: On the basis of and manner stat	examination and/or inv	occurred at the time, o estigation, in my opinion	date and place, a on, death occurre	and due to the cause ed at the time, date	e(s) and manno and place, and	er as stated. I due to the cause(s)
a a		OOD Cinneture and title of a failing			29c. License nu	ımber	29d.	Date signed (A	Month, Day, Year)
completely	_ :	29b. Signature and title of certifier	/						
To the complet	_ :	29b. Signature and title of certifier	- /m-		1)47	3725		2/4	105

		1 - For State Registrar	State	of Maryla	and / Depa <i>Ce</i> a	artment rtificate				, ,	jiene	005	0391
Physic		Decedent's Name (First, Mide			1 61			_	and a	2. Date of Dea	th Day	Year	3. Time of Death
/Medi Exami		4a. Facility Name (If not instituti		umber)	nter	4b. City, T			of Death		_	ounty of Death	
Funeral Director		5. Social Security Number 215-34-8522	6. Sex 1 □ M 2√2 F	7. Age (In yr	rs. last birthday) Yrs.	If Under 1 Months	Year Days	If Under	Min.	B. Date of Birth (Month, Day	, Year)		place (State or Foreign intry) LYVland
ryland how		Usual Residence of Decedent 10a. State 10b. Count	dy	10c. (City, Town or Lo	cation							10d. Inside City Limits
h the Ma or 28e-1 s	Director	Maryland Bo	altimore			10f. Zip C	ode		Edo	gemere	l0g. Citize	on of What Cou	1 ☐ Yes 2½ No intry?
if e, INGI yial I G F I Z I D-0050 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "neturel", or items 23a or 28e-1 show other treumatic event, the Medical Examinar must be notified at	Funerai D	2513 Wagner 2 11. Marital Status 1 □ Never Married 2 🖫 Ma	12. Was De		U.S. 13.	Was Decede f Yes, specif	nt of His y Cuban	212 spanic Origin, Mexican		ify Yes or No- ican, etc.)		ited St Race - Amer Black, White	ican Indian,
hours aff	by	3 ☐ Widowed 4 ☐ Divorce	If Yes (s 2€ No 3ive Dates:	2005	1 ☐ Yes 2		Specify:				pecify: Volume 1 of Business/II	hite
d within 72 giene. In then "ne	Completed		est grade complete	d) (1-4or 5+)	(Give	kind of work DO NOT use omemak	done du retired)	ırina most	t of working			Own Hor	•
id be filed lental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle Vincent Vecc			·			18. Mothe	,	(First, Middle, i Matran	Maiden Si		
and 2 should salth and Men n 27 is marke		19a. Informant's Name/Relation Mr. Henry A. S				-				Route Number			
Pages 1 and of Hee		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 1 □ Donation 5 Ø Other		n Slate	Place of Dispo cemetery, crer	natory or oth	er place,	·	Da			ition - City or T	own, State Mills, MD
paritinote, permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other once.		21. Signature of Foreral Service			22	. Name and Duda—F	Address Ruck	of Facility Fune	y ral E	Home of	Dun	dalk, 1	Inc.
Physician		23a. Part1. Enter the disease, shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)			eath. Do not ent	er the mode	of dying,	, such as	cardiac or	ndalk, respiratory arr	Mary est,	land 2	Approximate Interval Between Onset and Death
/Medical Examiner	Ĺ		b 3T(ost co	RONAF	RY F	RTE	RY B	YPAS5			48 HIJURE
cate be executed physician and the burial-transit	dicai Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	SURGE o (or as a conse	RY	CHEA	ART	DIS	LABE				
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely tilled in by the tuneral director, page 2 should be detached for use as the burial-transit	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 Live	outcome of preg birth 2 Fe gnant at time of known	etal death 3	Ectopic preg Other (spec					230	d. Date of deliv	ery Day Year
requires that een signed b	by P	Part II. Other significant condi	tions contributing to	death but not re	esulting in the u	aderlying cau	ise given	n in Part I.			oacco use	. /	he cause of death? pably 4 □Unknown
The taw recall that the real that has be page 2 sho	Completed									24a. Was a autops perform	y	24b. Were auto prior to co death? 1XX Yes	opsy findings available impletion of cause of
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	ition; To Be	25. Was case referred to medic examiner? 1 Yes 2 No 27. Magner of Death 1 Natural 5 Pend 2 Accident inves	Hospital: 28a. Dat	Inpatient 2 e of Injury onth, Day Year)	ER/Outpatien 28b. Time of Injury		Other Unjury a Work?	4 □ Nur	rsing Home 28	Check only on 5 Reside d. Describe ho	ence 6		(9)
el or Atters after dea	Certification;	3 ☐ Suicide 6 ☐ Could	mined 286. Pla	ce of Injury - At ding, etc. (Spec	home, farm, str cify)	eet, factory, o	office		28	f. Location (St. City or Town	reet and M n, State)	Vumber or Rura	al Route Number,
he Hospitt in 24 hours he Funere pletely filte	Medical (29a. Certifier 1 Certify (Check only 2 Medics	ing Physician: To the I Examiner: On the and ma	ne best of my ki basis of examin	nowledge, death	occurred at restigation, in	the time my opin	, date and nion, deat	d place, and h occurred	d due to the ca at the time, da	ause(s) an	nd manner as s ace, and due to	tated. the cause(s)
with Common	N	29b. Signature and title of certif	PAtem	D RH	wlgist	29c. I	License (number 3452	F-15	29	9d. Date s	gned (Month,	Day, Year)
HA		30. Name and address of perso	n who completed ca	use of death (Ite	em 23a) (Type,	Print)			-1" [53 - 2 V	rageri a	1 37		
Sta Regist	ate rar	31. Date filed (Month, Day, Yea	32. B 0 9 2005	Registrar's Sign		Soci	Es .				-		
DHMH 17 Rev 1/2	2001												

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death PEURUARY 6, **Physician** JEAN STANLE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** orthwest Hospital | Randallstown
| If Under 1 Year | If Under 24 Hrs. |
| Months Days Hours Min. | Baltimore 5401 Old Court Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) **Funeral** 1 □ M 2 X F 215-18-3291 Usual Residence of Decedent Director VILlania death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or itams 23a or 28a-f show the Medical Examinar must be notified at Maryland 1 Yes 2 No by Funeral Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. 314 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed withIn 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 (No Specify: 3 ₩ Widowed 4 Divorced lac Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College/(1-4or 5+) or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental int: if Item 27 ie marked o 19a. Informant's Name/Relationship (Type, Print) granddaughte 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name o Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State permit. Page Department of Important: if any injury or once. 2005 `4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Fune Bal 222 Wi North Avo. 23a. Part | Enter the d'a ase, or complications that chus id the shock, or heart failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immedia e Cause (Final disease or condition resulting in death) EPFLS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 signed by the attending physician d be detached for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Completed peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy this certificate 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other 1 Yes 2 No ဥ 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of 29d. Date signed (Month, Day, Year) 2008 npleted cause of death (Item 23a) (Type, Print) 30. Name and address MPSRIAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Depart State of Maryland / Depart State Registrar	artment of Health and M rtificate of Death	fental Hygie Reg.	Z U U G	03949
	Physicia	an	1. Decedent's Name (First, Middle, Last) Ann Louise Taylor		2. Date of Death Month February	Day 2005	3. Time of Death 3:00 A. M
Ī	/Medic Examin	_	4a. Facility Name (If not institution, give street and number) 206 Williams Road	4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arun	
	Funeral Director		5. Social Security Number 217-32-9223 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Jan. 27,	9. Birth 1936 Mar	place (State or Foreign ntn) yland
	the Maryland	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Low Maryland Anne Arundel Glen Bu 10c. Street and Number 10c. City, Town or Low		10g.	Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☐ No ntry?
98	perrait. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: it item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other treumatic event, the Macdical Extending an on-	Funerai	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 22(190No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ② No Specify:		14. Race - Ameri Black, White Specify: Wh	can Indian, etc.
Baltimore, Maryland 21215-0036	within 72 hours sne. than "natural", ne Macinal Ex	Completed by	(Specify only highest grade completed) (Give	ident's Usual Occupation is kind of work done during most of work DO NOT use retired) Realtor	ring	b. Kind of Business/li	
and 5	ld be filed vental Hygie ked other i	To Be Co	17. Father's Name (First, Middle, Last) Thomas Trimp	18. Mother's Nam	e (First, Middle, Mai		
Mary	alth and M	-	Paul C. Taylor / Son 206	ing Address (Street and Number or Rur Williams Rd. Gler			
imore,	Pages 1 a ment of He ent: If item ury or othe		1 FORBURAL 2: CHARMATION 3: IMBINOVALITORI STATE	osition (Name of matory or other place) n Mem. Pk. 200	0,	Len Burnie	
Balt	permit. Depart Import any inj			2 Name and Address of Facility irkley-Ruddick Fur 1 Crain Hwy. S.E.	Glen Burr	nie, MD 21	061 Approximate
1	Physician /Medical Examiner	iner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or minury) Due to (or as a consequence of):	Concer			Interval Between Onset and Death ONSET AND ONSET AND ONSET AND ONSET AND ONSET AND ONSET AND ONSET AND ONSET AND ONSET AND ONSET AND ONSET AND ONSET AND ONSET AND ONSET AND ONSET AND ONSET AND ONSET AND ONSET AND ONSET A
68760,	certificate be executed nding physician and use as the burial-transit	Medical Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of): d.				
O. Box	death ie atter ad for i	hysician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delin Month	very Day Year
rds, P.	Se 20 90	by P	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
Vital Record	The law ate has b page 2 sl	Completed				prior to c d? death?	opsy findings available ompletion of cause of
of	Attending Physicien: Thir death. ector: After this certificate by the funeral director, pag	ation; To Be	25. Was case referred to medical examiner? 1	ent 3 DOA Other: 4 Nursing He	th (Check only one) ome 5 \(\overline{\text{M}} \) Residence 28d. Describe how	e 6 ⊡Other (Specinjury occurred	ify)
Division	Dir Dir	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		City or Town, S		
	To the Hospitel within 24 hours of To the Funeral completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea (Check only one) 1 Medical Exeminer: On the basis of examination and/or is and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur 29c. License number	, and due to the caus rred at the time, date 29d	se(s) and manner as and place, and due . Date signed (Month	stated. to the cause(s)
	T wit		30. Name and address of person who completed cause of death (Item 23a) (Type	29c. License number 29c. License number 39 50 5 4 Print) Haspill	5 Fe	bruary	7,2005
	5	210-	30. Name and address of person who completed cause of death (Item 23a) (Type 23a). Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Resistrar's Signature.	Hospital Dr.	Clen 1.	Sumie	1 21061
	St Regist	ate rar	FEB 0 9 2005 Jenes St.	ypare			

			Unpend item#23	PII 27 perm	E, G84	Q.2/17/Q	5 TT	lental Hyd	Are Le	gible.		
		•	For State Registrar	nate of warytand		tificate of			Reg. No.	05	039	150
	Dh.		Decedent's Name (First, Middle, Last)					2. Date of Dea		Van	3. Time of	Death
	Physici /Medio		CAlvin 1	AYLOR				FEBRUA		2005	6:09P	. M
	Examir	er	4a. Facility Name (If not institution, give stre			•	r Location of Death		4c. Cou	nty of Death		
5	Funeral		424 E.LANVALE STRE 5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	BALTI If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	1	9. Birth	place (State o	or Foreign
Ž	Director		211-00 1900	^{2□F} 53	Yrs.	Months Days	Hours Min.	3-8-	(Year)	Cou	Ry Land	A
0	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Lo	cation					10d. Inside Çi	ity Limits
	h the Maryland r 28a-f ahow molified at	tor	Md	R	salt.	imbre					1 PYes	•
	¥ 69 €	Funeral Director	10e. Street and Number 424 E Lanuale	Street		10f. Zip Code	202		10g. Citizen	of What Cou	intry?	
	ams 23	Iner	11. Marital Status 12.	Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. F	Race - Ameri		
21215-0036	within 72 hours after ene. than "natural", or Ita ne Madical Examine	by	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		☐Yes 2 No	Specify:	, , , , , , ,	Spe	01	Lack	
15-0	"natural",	Completed	15. Decedent's Educati (Specify only highest grade co	on 1 ompleted)	(Give	lent's Usual Occup	during most of work	ing	16b. Kind of	Bu <i>s</i> iness/Ir	ndustry	
12	filed within Hygiene. thar than '	duo	Elementary/Secondary (0-12)	College (1-4or 5+)	IITO. L	DISAK			NA			
br	be filed stal Hygie of other event, II	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name			ame)		
ylaı		To	JAMES E JAYLO	R			Carri	e Bet	hea			
, Maryland	7.2 ₹ 3 € d		19a. Informant's Name/Relationship Type, Carrie Williams				and Number or Run Alle Ave	al Route Numbe BaL	r, City or Tov	vn, State, Zij	o Code)	
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem	20b. Plac	e of Dispos etery, crem	sition (Name of natory or other place	(9)	Date	20c. Locatio			
Ħ.	Pa mer ury		`4 □Donation 5 □Other (Specify)	1		n Park	2/10	1 - 0	_	to. N	ld.	
Bal	permit. Departr Imports any inje		21. Signature of Funeral Service Licensee	11:0	M	Name and Addre	ss of Facility 16	tan Cha	pel	Pro 1	md. 21	213
	4		23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one of	ons that caused the death. I	Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory arr	<u> </u>	, C.	Approximate Interval Bety	8
	Pnysician		Immediate Cause (Final disease or condition	Hypertensive							Onset and D	
	/Medical Examiner		resulting in death)	Due to (or as a consequen			JIDCCID					
	3.	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequen	ce of):							
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events									
760,	ite be executed lysician and ne burial-transit		resulting in death) Last	Due to (or as a consequen	ce of):							
687	a × a	dical	d.									
Box 6	requires that the death certifica een signed by the attending ph nould be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome of pregnancy					23d. I	Date of deliv	arv	
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)	'			Month	•	/ear
P.0	nat the d by th	Phys	9 Unknown					00 8111				
ds,	uires that the de signed by the a ld be detached f		Part II. Other significant conditions contrib End Stage Renal I		ig in the un	derlying cause giv	en in Part I.		paccouse co es 2⊡No		he cause of do	Jnknown
cor	~ Q 70	lete	Soobe Meriti	abcase				24a. Was a			ppsy findings a	
Vital Records,	0 5 0	Completed				· · · · · · · · · · · · · · · · · · ·		autops perfor	SV .	prior to co death? 1 🗷 Yes	mpletion of ca	luse of
/ita	yaician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?				26. Place of Death			1,92,403	20,10	
of \	ya dir	7 To	1 XYes 2 No Hosp 27. Manner of Death	1 □ Inpatient 2 □ ER	Outpatient		4 Li Nursing no				SCENE	1
OU	Jing After fune	tion	1 Natural 5 Pending 2 Accident investigation	8a. Date of Injury (Month, Day Year)	Injury	28c. Injun Worl	yat k? Yes 2 □ No	28d. Describe h	ow injury occ	urrea		
Division	Atter ector by the	Certification;	a Could not be	8e. Place of Injury - At home building, etc. (Specify)	, farm, stre		-	28f. Location (Si	reet and Nui	mber or Rura	al Route Num!	ber,
Ö	ospital or Attendours after death hours after death unaral Director: If filled in by the	Cer						City or Town				1
	To the Hospital or Attend Within 24 hours after death PTo the Funaral Director:	edicai	29a. Certifier 1 ☐ Certifying Physici. (Check only one) 2 ▼ Medical Examiner:	an: To the best of my knowled On the basis of examination and manner stated.	dge, death and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occurr	and due to the c ed at the time, d	ause(s) and ate and plac	manner as s e, and due to	tated. the cause(s))
	To the Tro the tro	Ž	29b. Signature and title of certifier	0		29c. License			9d. Date sign			
•	JU H		· Carol Hou	leur ma			C.M.E.		FEBRUA	RY 3,2	2005	
_	1000		30. Name and address of person who comp	eted cause of death (Item 23		•	STREET B	<u>ALTIMOR</u> I	E, MARY	LAND 2	21201	
*	Sta Registr		31. Date filed (Month, Day, Year) FEB - 9 2005	32. Registrar's Signature	house							

			For	State of	Marylan						ental Hyg	jiene	gibie.	
			1 - State Registrar			Cei	tificat	e of L	Death			eg. No	0.05	03951
	Physici	an	1. Decedent's Name (First, Middle								2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic Examin		Evelyn Virgin 4a. Facility Name (If not institution		ber)		4b. City,	Town, or	Location of	of Death	Februar	7	2005 nty of Death	1030A M
			437 Caledonia	Avenue					Lansd				Ba1	timore
	Funeral Director		5. Social Security Number 217-09-2519	6. Sex 1 ☐ M 2 X ☐ F	7. Age (In yrs. i 85	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,)ct. 2,	Year)	9. Birth	nplace (State or Foreign untry)
	ō		Usual Residence of Decedent								JCL. 2,	1919	Ma	ryland
	show	ŗ	10a. State 10b. County		10c. City	y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☒No
	the N	Funeral Director	MD B.	altimore			Lans	Sdown	ne		1	0g. Citizen o	of What Cou	
	th with 23e or	al Di	437 Caledonia	Avenue				2122	7				ted S	•
	tems:	uner	11. Marital Status	12. Was Dece Armed For	ces?	S. 13.				gin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)	14. F	lace - Amer	ican Indian,
336	urs afte	by F	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	If Von Chu	9		1□ Yes	2 ∑ No	Specify:			Spe	cify:	White
21215-0036	be filed within 72 hours after death with the Maryland hal Hyglene. ad other than "natural", or items 23e or 28a-f show event, I'm Medical Enath per meather collified at	Completed	15. Deceden	it's Education st grade completed)		16a. Deced	dent's Usua kind of wo	al Decupa	ation during mosi	t of workin	na	16b. Kind of	Business/li	ndustry
121	within ane. than "	mpl	Elementary/Secondary (0-12)	College (1-	4or 5+)	`life. I	DO NOT us	se retired)					
1d 2	e filed within al Hyglene. I other than " vent, the Me	Be Co	17. Father's Name (First, Middle,	Last)			HOI	nemal		or's Name	(First, Middle, I	Maiden Sum	Own name)	Home
ylar	should be and Mental marked c	ToB	Bernard Taylor	Sr.					Mar	garet	Langdo	on		
Maryland	2 6 5 6		19a. Informant's Name/Relations								Route Number			ip Code)
re,	la la la la la la la la la la la la la l		Charles J. Vain		20b. P	lace of Dispo	sition (Nan	ne of			nsdowne ate	MD 2 20c. Locatio		Town, State
imo	Page ment o ant: If ury or		1 Burial 2 ☐ Cremation 4 ☐ Conation 5 ☐ Other (S		tate La	emetery crem keview Par	Memo k	oria.	ľ	2-8-2	2005	Sykes	ville	. MD
Baltimore,	permit. Pages 'Department of the important: If ite any injury or ot once.	11	21. Signature of Funer Service	Dicens	inta				s of Facilit	y An	nbrose H	unera	1 Hom	e, Inc.
ī	40 = 40		23a. Part1. Enter the disease, or	complications that ca	used the death						Rd., La		ne, M	D 21227 Approximate
	Physician		shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on ea	ich line.						-			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (c	or as a consequ	uence of):	N S	0-1-14	, W C.,	(101-	HARTIC)w		
		er	Sequentially list conditions, if any, leading to immediate		or as a consequ	uence of):	ONC	C	17/1	o ute	curry	AF	EXSE	
	cuted od ransit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	S. HV	PEDI	14182	=wir	V.						
8760,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (d	or as a consequ	uence of):								
687	death certificate be executed e attending physician and of for use as the burial-transit	edical		d										
Вох	eath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	ome of pregna		Ectopic pr	ADDADOV				23d. [Date of deliv	/өгу
Ю. В	the att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ant at time of de		Other (sp					1	Month	Day Year
Δ.	law requires that the dias been signed by the 2 should be detached	by Ph	Part II. Other significant condition	ons contributing to de	ath but not resu	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did tob	pacco use co	ontribute to	the cause of death?
ords	w requires been sign should be		ALZIEI MEN	es Disk	45E						1 □ Ye	es 2□No	3 ☐ Pro	bably 4 Unknown
Vital Records,	e law re has be je 2 sh	Completed									24a. Was a autops	y i	prior to co	opsy findings available ompletion of cause of
al	Th ate	e Cor	25. Was case referred to medica									2 No	death? 1 Yes	2 No
	S S	To B	examiner?	Hospital:	patient 2	ER/Outpatien	t 3 🗆 DO	Othe			(Check only on		Other (Speci	ify)
n of			27. Manner of Death 1 Natural 5 Pendir	28a. Date o (Month	f Injury n, Day Year)	28b. Time of Injury		8c. Injury Work	at (?	2	8d. Describe ho			,,
Division	ten feat for: the	ficat	2 Accident investi	not be	of Injury - At ho	ome, farm, str	M eet, factory		Yes 2□I		8f. Location (St	reet and Nu	mber or Rui	ral Route Number,
ā	tel or / s after al Dire ed in b	Certification:	4 Homicide	buildin	g, etc. (Specify	()	,,	,			City or Town			
	To the Hospitel or Al within 24 hours after of To the Funeral Direc completely filled in by	edical	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the Examiner: On the ba and mann	sis of examinal	wledge, death tion and/or inv	occurred restigation,	at the tim , in my op	e, date an	d place, a th occurre	nd due to the ca d at the time, da	ause(s) and a ate and place	manner as e, and due	stated. to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifie	r			290	. License	0		2	9d. Date sign	ned (Month	. Day, Year)
	1/1		Drutt		>		1	130	408	>		3/1	1/01	
	111		30. Name and dress of fer on	Mo complete cause	Pori	A A	mi	mo	ME	mi	>1:	~30		
	Sta		31. Date filed (Month, Day, Year)	32. R	hisfrar's Signa	ture	p = 1	4	10					
	Regist	ar	FEB 0:	9 2005	seve.	D. 16	parti							

16/50

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
--	--------------------------------

			For State Registrar	State of Maryland	•	rtment of He			Z U	05	03952
			Decedent's Name (First, Middle, Last)	,				2. Date of Dea		Vaar	3. Time of Death
	Physicia /Medic		WILLIE	۷,	-	U11501	5	Februa	uy 2,	2005	9:44 Am
	Examin		4a. Facility Name (If not institution, give	street and number) Balh	inac	4b. City, Town, or	hocation of Death		4c. Cour	nty of Death	A
	Funeral Director		12-38-1172	7. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day	, Year) 1,195/	9. Birthp Coun NOR	ace (State or Foreign try) THE CAROLINA
Marylend	fshow	or	Usual Residence of Decedent 10a. State 10b. County		Town or Loc	27	TI WAR	n Ni.	T1/	11	0d. Inside City Limits
death with the Marylend	a or 28e- the ricitif	Direct	10e. Street and Number	DA AVENUE	<i></i>	10f. Zip Code	TIHORI		10g. Citizen o	of What Coun	try?
	niai Hygiene. nd other than "natural", or liema 23a or 28e-f show event, tre Medical Exaciling mant by rollflad at	Funeral Directo	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No		Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. R	lace - Americ lack, White,	
2 hours after	atural, or	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	16a. Deced	Yes 2 No	Specify:		Specific Spe	Business/Inc	ACK
CIZIZ D	giene. er than "n it's Medi	Completed	(Specify only highest grad	College (1-4or 5+)	(Give I life. D	kind of work done di 00 NOT use retired) ETERA	uring most of work	ring	4.5	5 , AA	2mV
2 2	nd Mental Hygi marked other matic event, I	To Be C	17. Father's Name (First, Middle, Last) FREDDIE L	EE WILS	SON		18. Mother's Nam	e (First, Middle,		ame) ORRI	5
Raryia 2 should	le me		19a. Informant's Name/Relationship (T)	(pe, Print)	19b. Mailin	g Address (Street a	nd Number or Rui	al Route Numbe	r, City or Tow	vn, State, Zip	Code)
More, I	it of Health and Mer. If item 27 le marke or other treumatic		DRINDLE (-1LLI 20a. Method of Disposition 18 Burial 2 □ Cremation 3 □ F	can	ce of Dispos netery, crem	sition (Name of natory or other place		AVE.	20c. Locatio	n - City or To	wn, State
GAILLIM Dermit. Pa			'4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licens		RR150	Name and Address	ST 02-	11-05 ROWN	JR.	FUNE.	RAL HOME
4 0			23a. Part1. Enter the disease, or comp	inations that caused the death	Do not ent	140 N.	FULTO	NAVE	,	TO. M	D. 21217 Approximate
1	nysician Medical		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseque	Hor		perte			scrd)	Interval Between Onset and Death
1 /m	xaminer	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	ince of):						
ate be executed	ohysicien and the burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):						
≝ٍ ۵	ng ph) as th	Medi	IF FEMALE:								
e da da	e etter	ysician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnand 1□Live birth 2□Fetal d 4□Pregnant at time of dea 9□Unknown	leath 3 🗆	Ectopic pregnancy Other (specify)				Date of delive Month	ny Day Year
Ords, F.O	signed by	d by Physi	Part II. Other significant conditions co	ntributing to death but not result	ing in the ur	derlying cause give	n in Part I.		obacco use co		e cause of death?
He ta	has b	Completed							rmed?	prior to con death?	osy findings available inpletion of cause of
	is certificate director, pag	Be C	25. Was case referred to medical examiner?		,		26. Place of Dear		2 No	1 🗆 Yes	2[]46
OT VITA		၉	1 Yes 2 100		R/Outpatien		4 Nursing H	ome 5 Resid)
C 2	fter	Certification;	27. Manne of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury Work M 1 \(\text{Y}	at ? ′es 2 □ No	28d. Describe h			
DIVI	within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di		4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)				City or Tox	vn, State)		Route Number,
the Host	hin 24 hoi the Fune npletely fi	Medical	(Check only 2 Medical Exam	sician: To the best of my knowl iner: On the basis of examination and manner stated.	ledge, death on and/or inv	estigation, in my op	inion, death occur	red at the time,	date and plac	e, and due to	the cause(s)
To	within To th compl	-	29b. Signature and title of certifier Received	yde		29c. License			29d. Date sig Febr		-
	5+1			express 240	23a) (Type, W. [Print) BELVEDE	ee Ave	Borce	more	un	2,2005
	Sta Registi		31. Date filed (Month, Early Year) 9 2	32. egistrar's Signatu	A	and I					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last 2. Date of Death **Physician** GNES /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4669 Fall'S R9 Examiner Palto MD 2120 Balto mD Care KOLGNG If Under 24 Hrs. 5. Social Security Number 6. Sex Z. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 1 M 2 P Yrs. Director 215-12-5436 83 January 13 1922 VIŔGINIA Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23e or 28e-f show the Medical Examiner must be notified at 1 XYes 2 ☐ No Director BALTIMORE MARYLAND N/A10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? PAYSON STREET 21217 U.S.A. 1709 N. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ANO If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: BLACK þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE N/A 12th grade permit. Pages 1 and 2 should be filed i Department of Health end Mental Hygis Important: If item 27 le marked other i eny Injury or other traumatic event, ≝ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MABLE S STEWART CLARENCE E MALTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3011 Spaulding Ave., Baltimore, Maryland 21215 Lureen E. Foote/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02-12-05 ARBUTUS MEMORIAL PARK BALTIMORE, MARYLAND 21. Signature of Funeral Service Livers 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Wollen 1206 W NORTH AVENUE 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death **Physician** NEUMONIA Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner by the attending physician and tached for use es the buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) resulting in death) Last be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has eged this certificete 1 Tyes 2 | ME 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Was case referred to medical Be 26. Place Ceath Check only one examiner? Hospital: Other: 4 Nursing Home 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural after death. Director: Aft 2 □ No 1 Tyes 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital or within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and classe, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) of I MILO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 ARMOTE(801 300

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

- 9 2005

32. Registrar's Signature

			For State Registrar	State of Maryla	•		of Heal	th and	Mental Hyg	iene		03954
	Physici		Decedent's Name (First, Middle, Last) Henry Warden						2. Date of Deat Month January	Day	Year 0.5	3. Time of Death 11:00 AIM
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, To	wn, or Loca	tion of Deat		4c. County		11.00 AH
	Xaiiiii	·.	Washington Adv	ventist Hospi	tal	Tako	oma Pa	ark			gomer	У
	Funeral Director		3/1-30-/00/	7. Age (In yrs	. last birthday) Yrs.	If Under 1 \ Months E		nder 24 Hrs urs Min.		^Y 1923	9. Birthpl Count	lace (State or Foreign try) UNK
	e Maryland a-f show	ctor	Usual Residence of Decedent 10a. Stateunk 10b. County	unk 10c. C	ity, Town or Lo	ocation				1	ınk d	1 Yes 2 No
	th with th	al Director	10e. Street and Number		uni	C 10f. Zip Co	ode		unk 1	0g. Citizen of V USA	Vhat Coun	iry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other traumatic avent, the Medical Examinal must be notified at once.	Completed by Funeral	11. Marital Status unk 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	unk	Was Deceden If Yes, specify 1 ☐ Yes 2 ☒		ic Origin? (S exican, Puer ecify:	Specify Yes or No- to Rican, etc.)		e - America k, White, e	
Maryland 21215-0036	within 72 ho ene. than "natu he Medical	ompleted	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) unk un	completed) College (1-4or 5+)	(Give	dent's Usual C kind of work of DO NOT use	done during	most of wo	unk rking	16b. Kind of Bu	siness/Ind	lustry unk
land 2	should be filed with nd Mental Hygiene marked other tha imatic avent, that	To Be Co	17. Father's Name (First, Middle, Last)			u	nk 18.1	Mother's Na	me (First, Middle, M	Maiden Sumam	re)	unk
	and 2 shou eaith and M n 27 is ma		19a. Informant's Name/Relationship (Ty Washington Advent						ural Route Number, Takoma Pa		State, Zip 209	
Baltimore,	Pages 1 a nent of Hea ant: if item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☒ Other (Specify)	emoval from State	Place of Dispo cemetery, crei				Date	20c. Location -	City or To	vn, State
Balt	permit. Departr Imports any inj		21. Signature Funeral S e Licens	Nade Directo	S B	Name and A tate Ai altimo	natomy re, MI	y Boar 212	d 655 W.	Baltim	ore S	treet
	/Medical Sician and Assistance of Parial-Itansil	Examiner	23a. Park. Enter the disease for complishoot or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection). Due to (or as a consection). Due to (or as a consection). Due to (or as a consection).	equence of):		1	ch as cardia	32	est,		Approximate Interval Between Onset and Death
.O. Box 68760,	death certifica e attending ph d for use as th	Physician/Medical E	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	f. 3c. tf yes, outcome of pregr 1	nancy tat death 3[⊒Ectopic preg □ Other (speci				23d. Dat	e of deliver	ry Day Year
s, P	ires sign	by	Part II. Other significant conditions con	_	sulting in the u	nderlying caus	se given in I	Part I.			ibute to the	e cause of death? abty 4 Unknown
Vital Record	Physician: The law requithis certificate has been al director, page 2 should	Completed								ned?	rior to com leath?	psy findings available inpletion of cause of 2000
ij	Physician: rthis certifica ral director, I	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{XNO} \)	lospital: 1 Inpatient 2[TER/Outpation	3 DOA	Othor		ath (Check only on Home 5 - Reside		ne (Canaite	
on of	ding I	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o		Injury at Work?		28d. Describe ho			,
Division	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str hify)	reet, factory, o	ffice		28f. Location (Sti City or Town		er or Rural	Route Number,
	the Hospital or hin 24 hours after the Funeral Dir npletely filled in	edical (29a. Certifier 12 Certifying Physical Check only 2 Medical Exami	sician: To the best of my kr ner: On the basis of examir and manner stated.	nowledge, deat nation and/or in	h occurred at vestigation, in	the time, da my opinion	te and place , death occ	e, and due to the ca urred at the time, da	use(s) and ma ate and place, a	nner as sta	ited. the cause(s)
•	To the within To the comp	W	29b. Signature and title of certifier	Regan		29c. L	icense num	21	25	JAN .		Day, Year)
			30 Name and address of person who co	ompleted cause of death (Ite	эт 23a) (Турв,	Print) Wa	cshe	neglo	m Ad	rentis	to	Losp.
	Sta Registi		31. Date filed (Month, Day, Year) FEB 0 9 200	32 Registrar's Sign	the So	arte		<i>y</i>				

DHMH 17 Rev 1/2001

ORIGINAL

			State Registrar	of Marylan		rtmen tificate			and M		Reg. No	005	<u> </u>	55
	Physicia	an	1. Decedent's Name (First, Middle, Last) Sarah Andrews Welsh							2. Date of De 02-07-2		Year	3. Time of 04:10	Death W
	/Medic		4a. Facility Name (If not institution, give street and	number)	_	4b. City,	Town, or	Location o				unty of Deat		
			Charlestown Retirement	Center			onsvi				Ва	1timor		
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2√	7. Age (In yrs. I F 83	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bird (Month, Da 7-17-19	h y Year)	9. Birt Co Mar	thplace (State or ountry) Cyland	r Foreign
Р			Usual Residence of Decedent							, 1, 1)	41	Hai		
anytan	show	J.	10a. State 10b. County		, Town or Lo								10d. Inside Cit 1 ☐ Yes	
the M	28e-f	ecto	MD Baltimore 10e. Street and Number	Cat	onsvil	LLE 10f. Zip	Code				10a Citizer	of What Co		- X
with	3a or	i Dir	709 Maiden Choice Lane	!			228				U.S.A		outiny :	
death	ems 2	Funeral Director	11. Marital Status 12. Was	Decedent Ever in U. d Forces?	S. 13. V			spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)			erican Indian,	
at yiallu 41413-0030 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Instural, or Items 23a or 28e-f show Important: If itam 27 Is marked other than "natural, or Items 23a or 28e-f show any Injury or other traumetic event, If a Medical Eventred must be notified at once.	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Y	es 2 No , Give or Dates:		I □ Yes		Specify:	, , , ,	, 110411, 010.)			Vhite	
2 hour	atural cul Ey	ted b	15. Decedent's Education		16a. Deced						16b. Kind	of Business/	Industry	
시 기 기 기 기 기 기 기 기 기 기 기 기 기 기 기 기 기 기 기	e. Me.li	Completed	(Specify only highest grade comple Elementary/Secondary (0-12) Colle	ed) ge (1-4or 5+)	life. L	kind of woi DO NOT us	rk done di se retired)	uring most	t of workii	ng		<i>!</i>	·	
N be	ygien har th	Con	12 2		Clerk			40.14-4-	d- No				of Defe	nse
d be fi	ad oti	Be c	17. Father's Name (First, Middle, Last) Cassian Andrews							(First, Middle,	maiden Su	mame)		
should	nd Me mark metic	유	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address	-	Ruth nd Numbe		es Il Route Numbi	er, City or To	wn, State, 2	Zip Code)	
and 2	alth a		Arthur C. Welsh/Son		6029	Clain	ce Dr	ive 1	E1kr:	idge MD	2107	5		
es 1.8	of He Mitam or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal f	om State	lace of Dispo emetery, cren	natory or o	ther place			ate		ion - City or		
mit. Pages	tant: tant: jury o		' 4 ☐ Ronation 5 ☐ Other (Specify)	Lou	2000					-2005	Balti	more,	Marylan	ıd
Dermi	Depar Impor any Ir		21. Signature of Fune A Service Lidensee	M	22 Au 1.3	Name an	Fun	s of Facilit neral	y Home	e Inc. Kd. Ar	butus	MO 21	227	
Dh	ysician		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause Immediate Cause (Final	on each line.	n. Do not ente	er the mod	e of dying	, such as	cardiac o	r respiratory a			Approximate Interval Betw Opset and D	veen
/[Medical kaminer			to (or as a consequ	Jence of):	V.E.	MEV	ART	18	ILURE			YEAR	.>
P	=	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	to (or as a consequ	uence of):									
J, execute	ohysician and the burial-transit	Examiner	that initiated events c.	to (or as a consequ	uence of);									
o / oU	hysicia the bur	dicai	d											
OX OX	ding p	/Med	IF FEMALE: 23c. If yes	, outcome of pregna	ncv						024	Date of del		
The law requires that the death certificate be executed	been signed by the attending pl should be detached for use as t	Physician/Me	in the past 12 months?	ve birth 2 Fetal regnant at time of de nknown	death 3	lEctopic pr] Other (sp					230	. Date of del Month	*	'ear
w requires that	n signed b Ild be deta	by	Part II. Other significant conditions contributing DEME		ulting in the ur	nderlying c	ause give	n in Part I.			obacco use ∕es 2□N		the cause of de	eath? Inknown
law re	s bee 2 shou	Completed								24a. Was		4b. Were au	itopsy findings a completion of ca	ivailable
	ate ha	Com								perfo	rmed?	death?		436 01
VICAL ician: 1	sertific ector,	Be	25. Was case referred to medical examiner? Hospital:						of Death	(Check only o	ne)			
Phys	n. After this certificate has funeral director, page 2	n: To	27. Manner of Death 28a. D	ate of Injury	ER/Outpatien 28b. Time of		8c. Injury	at	444	me 5 🗆 Resid 28d. Describe I			cify)	-
VISION Attending	ath. ir: Afte	atio	2 Accident investigation	Month, Day Year)	Injury	М	Work 1 □ Y	r ′es 2⊡i	No					
DIVIS I or Atte	after de Diracto d in by th	Certification:	3 Suicide 6 Could not be 28e. F	lace of Injury - At ho uilding, etc. (Specify	ome, farm, str	eet, factory	, office		2	28f. Location (: City or Tox	Street and N vn, State)	umber or Ru	ıral Route Numb	oer,
e Hospita	within 24 hours after death. To the Funeral Diractor: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) Certifying Physicien: T Medical Exeminer: On t and	the best of my kno ne basis of examina nanner stated.	wledge, death tion and/or inv	occurred vestigation	at the time in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) and date and pla	d manner as ace, and due	stated. to the cause(s)	
To th	withir To th comp	Me	29b. Signature and title of certifier	1		290	License	number	/ / /	·			h, Day, Year)	
1	N		14-5 V./	1-6		1	40	11	18		FEBR	UANT	8,20	105
6	110		30. Name and address of person who completed	cause of death (Item			M	מומ	EN	Cho	CE	1001	F. c	
1	Sta	ite	31. Date filed (Month, Day, Year)	2. Registrar's Signa	ture L	Spark	20	NID	570	BA	14 N	72/2	1228	
N. E	Registr		FEB 0 9 2005	Stoler	10.	STORY.								

			1 - For State Registrar	State of Maryland / I	Department of Certificate o			giene 0 0	5 03956
		п	Decedent's Name (First, Middle, Last)				2. Date of De.	ath	3. Time of Death
	Physicia /Medic		Ronald Harold	Wolf			02/05		7:15 P ^M
	Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town	, or Location of		4c. County o	
			9 Senate Drive		Pasa				Arundel
П	Funeral Director		5. Social Security Number 6. Security Number 219-26-9618	M 2DE	rthday) If Under 1 Year Months Day		8. Date of Bird (Month, Da 0 7 / 0 4)	h y Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent	66			07/04,	/1938	MD
	ryland how		10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits
	e Ma Sa-f s	cto	MD Anne Arı	undel Pasa	adena				1 ☐ Yes 2 🔀 No
	or 28	Director	10e. Street and Number		10f. Zip Code	9		10g. Citizen of WI	nat Country?
	s 23e	rai	9 Senate Drive		211			U.S.A	<u> </u>
	Item Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1955-	13. Was Decedent o	of Hispanic Origi uban, Mexican, i	n? (Specify Yes or No- Puerto Rican, etc.)	- 14. Race Black	- American Indian, White, etc.
980	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1958	1 ☐ Yes 2 🛣 N	lo Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show the Madical Examinatinish be molified at	Completed	15. Decedent's Edu (Specify only highest grade	cation 16a	. Decedent's Usual Occ	cupation	d madrine	16b. Kind of Bus	iness/Industry
7	ithin ne.	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work dor life. DO NOT use reti	ired)	or working		
	filled w Hygier other tl	S	17. Father's Name (First, Middle, Last)		Meat Sty			Grocer	
Maryland	ntal he of	Be	, , , , , , , , , , , , , , , , , , , ,				s Name (First, Middle,)
2	2 should and Men Is marke aumatic	ဥ	Harold Wolf 19a. Informant's Name/Relationship (Ty)	pe. Print) 19h	. Mailing Address (Stre		1ma Cron:		tato Zin Codo)
	and 2		Constance Wolf/V		Senate D				
re,	es 1 a of Hea filtern r othe		20a. Method of Disposition	20b. Place o	f Disposition (Name of ry, crematory or other p		Date		ity or Town, State
Ĕ	Pages nent of I int: If Its iry or o		1 X Burial 2 □ Cremation 3 □ R 14 □ Donation 5 □ Other (Specify)	diliuval il ulil State	eteran Cei	1	2/08/05	Crownsv	ille. MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examination into Intiliad at once.		21. Signature of Funeral Service License						al Home, PA
_	80 E 9 9		12/1	ie	169 Riv	<u>iera D</u>	rive, Pas	sadena,	MD 21122
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death. Do no cause on each line.	y priling	lying, such as ca	ardiac or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	sunda	y pula	nonav	y hyper	funn	Onset and Death
ì	/Medical Examiner		resulting in death)	Due to (or as a consequence		_	10		
		er	Sequentially list conditions, if any, reaging to immediate	Due to (b) as a consequence	off.				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,				
o	an an arial-tr	Exa	resulting in death) Last	Due to (or as a consequence	of):				
8760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	dical		l					
9	death certifics attending ph	/Mec	IF FEMALE:	0. 16					
Box	attend for us	Physician/Me	in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	=			23d. Date Mont	
o.	that the de	ysic	1 Yes 2 No 9 Unknown	9□ Unknown	5 ☐ Other (specify)			-	,
s, P	s that ned b	by Pr	Part II. Other significant conditions con	tributing to death but not resulting in	n the underlying cause of	given in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
rds	w requires been sign should be						1 🗆 Y	es 2 No 3	☐ Probably 4 ☐ Unknown
Record	aw Is b	Completed					24a. Was :		ere autopsy findings available
	The law rate has b page 2 sl	E O				-	— autop perfor 1 ☐ Yes	mad2 de	or to completion of cause of ath? Yes 2 No
Vita	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?				Death (Check only of		
	% v □	2	1 ☐ Yes 2.2 No	ospital: 1 Inpatient 2 ER/Ou		Other: 4 🗌 Nursi		ence 6 Other	1 1 77
n C	ding After fune	ion	27. Manner of Death 1 Natural 5 ☐ Pending		Time of 28c. Injury W			ow injury occurred	1
Division of	deal deal ctor: y the	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, fa		☐ Yes 2 ☐ No		Treet and Number	or Rural Route Number,
<u>S</u>	2 4 5 5	Certification;	4 Homicide determined	building, etc. (Specify)	in, street, factory, only	o a	City or Tow	n, State)	or naral noble Number,
	To the Hospital or within 24 hours aft To the Funeral Dil completely filled in		29a. Certifying Phys	sicien: To the best of my knowledge	e, death occurred at the	time, date and p	place, and due to the	ause(s) and manr	er as stated.
	24 19 Fi	ledical	one) 2 Medical Exemir	ier: On the basis of examination an	d/or investigation, in my	y opinion, death	occurred at the time, of	date and place, an	d due to the cause(s)
	윤 등 등 등	-	29b. Signature and title of certifier	1111	29c. Lice	nse number	2/	29d. Date signed (Month Day Vers
	To the Hospital of within 24 hours all To the Funeral D completely filled in	Σ	1 /AAIAAha			111111111		2//-	Month, Day, Year)
	To th within To th		· www.	nne	1	14480	9	2/7/05	Month, Day, Year)
Ĺ	within within comp		30. Name and address of person who co	mpleted cause of death (Item 23a)	(Type, Print)	14480 + svite	134 060	2/7/03 adena	MID 21/22
Ĺ	Vithin Vithin Comp	te	29b. Signature and title of certifier WMWM 30. Name and address of person who co Kann M Ord 31. Date filed (Month, Day, Year) FEB 0 9	mpleted cause of death (Item 23a) G MO SU 25 R 32. Register's Signature	(Type, Print) Hilve Huy	19980 4 sixte	134 Pas	2/7/03 aduna	MD 21/22

			-						d Mental Hy	are Legible).
			1 - For State Registrar	Otato of IVI	arytaria /		rtificate of l			Reg. No.	5 03057
			1. Decedent's Name (First, Middle,	Last)					2. Date of De	ath	3. Time of Death
	Physici /Medi		ANDREW (Tal	17854 W	(auth)	ER	111		FabRaph	24 3, 200	- 4 414
	Examir		4a. Facility Name (If not institution,				4b. Çity, Town, or	Location of D		4c. County of D	
				grow Ao	ENUE	=		down.		BAL	TMORE
	Funeral		5. Social Security Number 218–28–4488	. Sex	je (In yrs. last bi 71	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 I Hours N	Ain. (Month, Da	th y, Year) 9.	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		7 1				Feb. 4	, 1933 1	Maryland
	rylanc how		10a. State 10b. County		10c. City, Tov	vn or Lo	ocation				10d. Inside City Limits
	Ba-f s	ctor	MD Bal	timore			Lansdowr	ne			1 ☐ Yes 2 📉 No
	or 28	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?
	s 23a	ral	624 Washington				212			United S	States
	Item	nu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 📉		13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? n, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)	- 14. Race - A Black, W	merican Indian, Ihite, etc.
936	ursat el', or	b	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	140		1□Yes 2□XNo	Specify:		Specify:	White
21215-0036	within 72 hours atter death with the Maryland ene. then "neturel", or items 23a or 28a-1 show he Modrell Exception	Completed	15. Decedent's (Specify only highest	Education	16a	. Dece	dent's Usual Occupa	ation		16b. Kind of Busine	ess/Industry
21	d within 72 ho giene. r then "netu the Modical	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of work done of DO NOT use retired	uring most of	working		
12	77 75 2 20		12 17. Father's Name (First, Middle, La				Meat Cutt				ant Food
anc	be do do	Be		,					Name (First, Middle,	Maiden Sumame)	
Maryland	2 should be and Menta Is marked sumatic ev	T _o	Andrew G. Walth 19a. Informant's Name/Relationship		19	Mailir N	an Address (Street a		th Sayman	er, City or Town, State	7 0 11
Z	d 2 s th ar 7 ls trau			x-Wife							
ē,	es 1 an of Heal f item 2 r other		20a. Method of Disposition		20b. Place d	of Dispo	sition (Name of	1	Date	g MD 2104 20c. Location - City	or Town, State
Ē	mit. Pages partment of cortent: If it injury or o		1 Burial 24 Cremation 3		Bayvi	ew"	Crematory Inc		- 7-2005	Baltimore	MD
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Lit	ensee	00	22		s of FacilityAI	mbrose Fur	neral Home	. Inc
_	207299		Collum	61) MM	LXX.	1 2	719 Hammo	nds Fer	rry Rd I	ancdormo	MD 21227
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that caused ly one cause on each li	the death. Do	not ent	er the mode of dying	g, such as card	diac or respiratory ar	rest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. CTVOSA	DTWO.	Jr	d To	HeAd			Onset and Death
	Examiner			Due to (or as	a consequence	of):	,				
		Jer.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence	of):					
	ate be executed hysician and the burial-transit	Examiner	that initiated events	c							
Ő,	e exe ian ar urial-t	Ex	resulting in death) Last	Due to (or as	a consequence	of):					
8760,	The taw requires that the death centificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		d							
9	leath certifical attending phy I for use as th	/Me	IF FEMALE:	23c. If yes, outcome	of progpages						
Вох	atten atten I for u	clan	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
P.O.	that the dended by the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
	es tha igned l	ру Р	Part II. Other significant conditions	contributing to death b	ut not resulting i	in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Records,	w require been si should t								_ 1□Y	'es 2 ☑ No 3 ☐	Probably 4 Unknown
ec	has be	ompleted							24a. Was a	an 24b. Were	autopsy findings available o completion of cause of
<u>E</u>		Con							perfor 1 ☐ Yes	med death	? es 2□No
Vital	Physicien: 'r this certifica	Be	25. Was case referred to medical examiner?	Hospital:			Otho		Death (Check only or		
of	ding Phys h. Atter this funeral di	: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie		tpatien	t 3 DOA Othe	4 Nursing		ence 6 Other (S	pecify)
ion	Attending F r death. sctor: Atter by the funer	atlo	1 □Natural 5 □ Pending 2 □ Accident investigat	ion reberary		Injury	Work	es 2 No	Solf	5 P 1 5	
Division	of or Attendiate after death. Director: A in by the fu	Certification;	3 Suicide 6 □ Could not determine	One Diege offer	ury - At home, fa	arm, str	eet, factory, office		28f. Location (S	treet and Number or	Rural Route Number,
	itel or rs afte rel Dir led in l	Cer		L. L.	10mg				624/1/	DSL OCIA	LEVE MARYLAND
	Hospitel 24 hours a Funerel I	Medical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best aminer: On the basis of	examination ar	e, death	occurred at the time	e, date and pla	ace, and due to the c	cause(s) and manner	as stated.
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Med	29b. Signature and title of certifier	and manner sta	ated.		29c. License			29d. Date signed (Mo	
	F 3 F 8		Vinn	<		1				_	
•	AU		30. Name and address of person with	completed cause of d	eath (traff 23a)	(Туре,	Print)	1/17	/	SPRUARY 4	4,2005 Brid 21042
1	Q'		E. P. Williamson	13933 N	E Joh	NS	LANE.	ELLIC	CITICITE	1 MARIL	Brid 21042
	Sta		31. Date filed (Month, Day, Year)		Signature					1-11-1-1	
	Registr	ar	LER	9 2005	low	S.	books				

			1 - For State Registrar	State of Maryla	nd / Departn	nent of Health	and Me	ental Hyg	iene 2005	03958
			Decedent's Name (First, Middle, La	st)	Octun	ale of Beat		2. Date of Deat	ng. No.	3. Time of Death
	hysici		MILDRER	WELNO	SKU			Month 726	Day Year	9:35 AM
	/Medic xamin		4a. Facility Name (If not institution, giv			City, Town, or Location		700	4c. County of Deal	
	Aaiiiiii	C1	3201 Willough			PARKVIII			BALTI	
Fu	neral		5. Social Security Number 6.5	ex 7. Age (in vrs		Inder 1 Year If Unde		B. Date of Birth (Month, Day,	9. Birt	hplace (State or Foreign
	ector		217-22-1378	OM 2015 8	8 Yrs. Mo	nths Days Hours	Min.	March 1	1. 1916 Co	hplace (State or Foreign
ъ.			Usual Residence of Decedent							
arylar	or cea-1 snow se notified at	_	10a. State 10b. County		ity, Town or Location					10d. Inside City Limits
e Ma	diffe	cto	MD BAL	Timore	27	ARKVILLE				1 ☐ Yes 2 No
il th		Oire	10e. Street and Number		10	f. Zip Code		10	Og. Citizen of What Co	
should be filed within 72 hours after death with the Maryland Mental Hygiene.	o oner tran natural, or lama 23s of 20s-1 snot event, the Madical Examinar must be notified at	Funeral Director	3201 Willoug	hby R.S.		2123			U.5. F	7.
de l	BL TI	nue	11. Marital Status	12. Was Decedent Ever in Armed Forces?	J.S. 13. Was I	ecedent of Hispanic C specify Cuban, Mexic	Origin? (Speci an, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit	
s afte		by Fi	1 Never Married 2 Married	1 Yes 2 No		es 22 No Specif			0 - 5 %	1
hours	I Ex	Q D	3. ☐ Widowed 4 ☐ Divorced	Year or Dates:						かけて
2 2 2	adic a	Completed	15. Decedent's E (Specify only highest gr		(Give kind	Usual Occupation of work done during mo OT use retired)	ost of working	7	16b. Kind of Business	Industry
withii	Die M	m d	Elementary/Secondary (0-12)	College (1-4or 5+)		Ffice			LUENDOVE	R INC
Hygin N	nt, in	ပိ	17. Father's Name (First, Middle, Last				ther's Name (Maiden Sumame)	4-1-6
ld be fill ental H	9 9 0 9 0	00		LTER			nary		and on our annoy	
d Me	Tark	ဥ	19a. Informant's Name/Relationship		19h Mailing Ad	iress (Street and Num.			City of Tourn State	7in Code)
d 2 s th an	trau			- AMER	3201	9				-
Heal a	other		20a. Method of Disposition		Place of Disposition	Willough b	Da	te 2	20c. Location - City or	
Pages nent of	0 0		Burial 2 Cremation 3	Removal from State	cemetery, cremator	or other place)	2/2/	26	BAIto. No	
Dailinor	important: If Itam 27 is marke any injury or other traumatic <u>pnce.</u>		' 4 □Donation 5 □ Other (Special Service Lice		Akdens of	mith	allia.	03	BAITO NOS	6 (5)
Dailing permit. Pages Department of	any l	İ	21. Signature on Fulleral Service Lice	- fiel.	It A	ne and Address of Fac 1744 M. U.C. 27 has For	- 57c	119 70	necal Item	e CHO.
			222 Bort Enter the disease or com	plinations that says ad the de-						
			23a. Part1/Enter the disease, or com shook, or heart failure. List only	one cause on each line.		_	_	respiratory arre	ist,	Approximate Interval Between Onset and Death
Phys	ician dical		Immediate Cause (Final disease or condition resulting in death)	a Congestiv	e Hea	4 FAIL	one			2 years
	niner		•	Due to (dr as a conse	quence of):					. 1
		10	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a conse	directe of):					
pel	nslt	nine	Cause (Disease or injury	500 10 (01 40 4 501104	4001100 01).					
xecu	al-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as a conse	quence of);					
	nysician and the burial-transit	icai E								
certificate be executed	pnys s the	edic		d						
Certif	been signed by the attending pr should be detached for use as ti	/We	IF FEMALE:	23c. If yes, outcome of pregi	nancv				23d. Date of del	ivani
death cer	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		pic pregnancy ar (specify)			Month Month	Day Year
j g	y me	Physician/M	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown		(0,000.,)				
ords, F.C	deta		Part II. Other significant conditions	contributing to death but not re	sulting in the underly	ing cause given in Par	rt I.	23e. Did tob	acco use contribute to	the cause of death?
COLOS w requires	d be	d by						1 ☐ Ye	s 2 No 3 Pr	obably 4 Unknown
	shou	ompieted						24a. Was ar	24h Were a	Itopsy findings available
The law	page 2	ᇤ						autops	y prior to	completion of cause of
	certificate rector, pag	e Cc	Of Manager of and to made to						No 1 ☐ Yes	2 No
		o Be	25. Was case referred to medical examiner?	Hospital:	7500	Other		Check only on		
o f	ral di		1 ☐ Yes 2 🖪 No 27. Manner of Death		ER/Outpatient 3	J DUA 4 I			nce 6 Other (Spe w injury occurred	city)
ding -	Affe	tion	1 ■Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes 2 [www.njery coosings	
OIVISION or Attending after death.	ctor: y the	ertification:	3 Suicide 6 Could not b	Ole Place of Injury At				If, Location (St	reet and Number or Ri	ıral Route Number
lor /	d in	erti	4 ☐ Homicide determined	building, etc. (Spec	rify)			City or Town		
LIVISION OF TO the Hospitel or Attending Physikin 24 hours after death.	fillec	O	29a. Certifier 1 Certifying P	nysician: To the best of my kr	nowledge, death occ	rred at the time, date :	and place, an	nd due to the ca	uise(s) and manner as	stated
24 h	e Fui etely	ledical	(Check only 2 Medical Exa	niner: On the basis of examinand manner stated.	nation and/or investig	ation, in my opinion, de	eath occurred	at the time, da	ate and place, and due	to the cause(s)
ithii	о пр	Me	29b. Signature and title of certifier			29c. License number	ır	25	9d. Date signed (Mont	h, Day, Year)
- s i	- 0		> //			1) 38	8048		-(3/05	
	13		30. Name and address of person who	completed cause of death /tte	am 23a) (Type Print	- 00				
	10		9106 Dh	iladelnhio	- Ral #	304 Back	timor	e m	0 212	37
	Sta	ite	31. Date filed (Month, Day, Year)	. Registrar's Sign						
F	316 Reaisti		EED 0 0 200	5 Reduce 1	& Brook	9				

			1- State of Maryl	and / Department of Health and M Certificate of Death		2005	03959
			Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physicia /Medic		Walter H	Frank Wiatr		Day Year 1, 2005	5:05 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			8410 Cove Road	Dundalk vrs. last birthday) If Under 1 Year If Under 24 Hrs.	0.00-1(0)-1-	Baltime	
	Funeral Director		5. Social Security Number 219-12-6373 Usual Residence of Decedent 6. Sex 7. Age (In the second sec	yrs. last birthday) Yrs. If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Y) Aug. 5,1		lace (State or Foreign try) aware
	/land			City, Town or Location		1	0d. Inside City Limits
	death with the Maryland ms 23s or 28s-f show rnust be trufffed at	ctor	Maryland Baltimore	Dunda	alk		1 ☐ Yes 2 ☑ No
	or 28	Director	10e. Street and Number	10f. Zip Code		. Citizen of What Coun	try?
	ath w		8410 Cove Road	21222		United St	
	ter de	Funeral	11. Marital Status 12. Was Decedent Ever i Armed Forces? 1 □ Never Married 2 □ Married 14-14-14-8 2 □ □ No	n U.S. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
20	hours after tural', or Ite	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: ₩₩	1 ☐ Yes 2½ No Specify:		Specify:	White
212-0036	be filed within 72 hours after death with the Marylan ital Hygiene. Id other then inatural; or liems 23s or 28s-1 show event, the Markest Exercities out the collified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of worki	16	6b. Kind of Business/Inc	
7	within 72 ene. then "nai	mpie	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	9		
7	filed v Hygie Sther ti ent, th	Co	1 Year 17. Father's Name (First, Middle, Last)	Amusement Machine Opera		Amusement	Parks
yland	id be lental lental l'ked o	To Be	Stanley Wiatr		filia Rod		
	shoutd and Men marke	-	19a. Informant's Name/Relationship (Type, Print) Daughto				Code)
, Mal	s 1 and 2 should f Health and Men item 27 is marke other traumatic		Mrs. Wilhelmina Watnoski	1239 South Clinton St	. Balti	more, Mary	land 21224
Baltimore,	Pages 1 nent of He int: If iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2★ Cremation 3 ☐ Removal from State	b. Place of Disposition (Name of cometery, crematory or other place)	Date 20	c. Location - City or To	wn, State
E	t. Pag tment tant: ijury		'4 □Donation 5 □ Other (Specify)	Hilltop Service Corp. 2/7,		Towson, Ma	
a C	permit. Pages 1 Department of H Important: If its any injury or otl		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Duda-Ruck Funeral H			
			23a. Part 1. Enter the disease of complications that caused the c	7922 Wise Ave. Dudeath. Do not enter the mode of dying, such as cardiac of			L222 Approximate
	Physician	6.	shock, or hear failure. List only one cause on each line. Immediate Cause (Final	1010 10			Interval Between Onset and Death
r	/Medical		disease or condition resulting in death) a. Due to (or as a con	sequence of):			mania
	Examiner		Sequentially list conditions, b. Chun	u renal failure			15 415.
٦	ed sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence of):			15
In.	xecut and al-trar	Examin	that initiated events resulting in death) Last C. Due to (or as a con	sequence of):			17915
09/8	icate be executed physician and s the burial-transit	edicai E	La Hya	estersion			1574
0		Nedi	IF FEMALE:	7			
X R R	leath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregnancy		23d. Date of delive	ry Day Year
	at the de by the a tached f	ysic	1 Yes 2 No 4 Pregnant at time 9 Unknown 9 Unknown	of death 5 🗆 Other (specify)	-	, and the	·
ב	The law requires that the death certif te has been signed by the attending page 2 should be detached for use a		Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to th	e cause of death?
g	w requires been sign should be	ed by			1 ☐ Yes	2 □No 3 ₽ Frob	ably 4 Unknown
ecords,	aw re	Completed			24a. Was an	24b. Were autor	sy findings available
r	a cr	Com			autopsy performe 1 Tes 2	d? death? 1 ☐ Yes	npletion of cause of 2 No
VII	or Attending Physician: Thiter death. Director: After this certificate in by the funeral director, pag	Be (25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
0	Phys this c	To	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 27. Manney of Death 28a. Date of Injury		me 5 Residence 28d. Describe how	ce 6 Other (Specify	")
0	th. th. After I	tion	1 Natural 5 Pending (Month, Day Yea 2 Accident investigation	28b. Time of 28c. Injury at Work?	Edd. Describe now	many cocumed	
Division	Atternation description of the	Certification	3 Suicide 6 Could not be 28e. Place of Injury -	At home, farm, street, factory, office	28f. Location (Stre	et and Number or Rura	Route Number,
בֿ	Ital or rs afte al Dir led in	Cert	4 Homicide building, etc. (Sp.	in the state of th	City or Town,	State)	
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: / completely filled in by the fi	Medical	29a. Certifier (Check only one) Certifying Physicien: To the best of my one) Certifying Physicien: To the best of my and manner stated.	knowledge, death occurred at the time, date and place, a nination and/or investigation, in my opinion, death occurre	and due to the cau ed at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
	To the vithin 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	290	I. Date signed (Month, I	Day, Year)
			· W/ M/	1)44193		2/2/0	5
	20+1		30. Name and address of design the completed cause of death	130 Holabud An	Bal	t' MOZ	1222
	Sta			ignature			
DH	Registr MH 17 Rev 1/2		7 FEB 0 9 2005	A Sports			
	1104 1/2	301		ORIGINAL			

				For State Registrar	State o	f Maryland /	•	rtment of H tificate of L		-	giene Reg. No:	05	03960
		Physici		1. Decedent's Name (First, Middle, Last)	Anna		W	ach		2. Date of De Month	Day	Year 2006	3. Time of Death 2:20 AM
		/Medic Examin		4a. Facility Name (If not institution, give s	treet and nu	mber)		4b. City, Town, or	Location of Death	· CDr torti		unty of Death	1
				Johns Hopkins BAY		MEDICAL CE		BALTIMO If Under 1 Year		8. Date of Bir	th	Q Birth	N/A
		Funeral Director			M 2⊠F	82	Yrs.	Months Days	Hours Min.	(Month, Da	ı <i>y, Year)</i>	Cor P	nplace (State or Foreign untry) Oland
		and W		Usual Residence of Decedent 10a. State 10b. County		10c. City. To	wn or Lo	cation					10d. Inside City Limits
		Maryli -f sho	tor		ltimor	6			Dunc	lalk			1 ☐ Yes 2 🖾 No
		th the	Director	10e. Street and Number	I CIMOL			10f. Zip Code	Dun	IGIN	10g. Citizen	of What Co	untry?
		ath wil		1710 Leslie Ro						1222		ted St	
	36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examilies must be rucillised at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3% Widowed 4 Divorced	12. Was Dece Armed Fo 1 ☐ Yes If Yes, Giv Year or D	2 ½] No ve	'	Vas Decedent of Hi Yes, specify Cubar ☐ Yes 2€ No	spanic Origin? (Spe n, Mexican, Puerto Specify:	cify Yes or No Rican, etc.)		Race - Ame <i>i</i> Black, White ec <i>ify:</i>	
	9-0	2 hour	ted t	15. Decedent's Edu	cation		a. Dece	lent's Usual Occupa	tion		16b. Kind o	of Business/I	
	Maryland 21215-0036	i within 7. jiene. r then "n	Completed	(Specify only highest grade Elementary/Secondary (0-12) 8 Years	College (1-4or 5+)		kind of work done d DO NOT use retired, eaning	uring most of worki)	ng		more (
	nd	al Hyg d othe	Be	17. Father's Name (First, Middle, Last)					18. Mother's Name	(First, Middle	, Maiden Sun	name) U	nk.
	yla	Ment Ment Marked Marked	2	Stanley Kozlows							-		
	Mar	d 2 sh th and 27 is m treum		19a. Informant's Name/Relationship (Ty				g Address (Street a					
	re,	item		Mrs. Danuta Craig 20a. Method of Disposition	•	20b. Place	of Dispo	23 Waters sition (Name of natory or other place		ate Duffic		on - City or T	
	Baltimore,	Page ment cent: If		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emovai trom	State	Stan	islaus Ce	m. 2/8/	2005			, Maryland
±	Balt	permit Depart Import any inj		21. Signature of Funeral Service License	98			Name and Addres uda-Ruck 922 Wise					nc.
JACH		Physician		23a Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final	1	caused the death. Do each line.	not ent	er the mode of dying	g, such as cardiac c	r respiratory a	rrest,		Approximate Interval Between Onset and Death
3		/Medical		disease or condition resulting in death)		(or as a consequence		CHUE	pulmon A	incy a	SEASE		Soyes
41		Examiner	J.	Sequentially list conditions, if any, leading to immediate	Due to	(or as a consequence	a of):						
ANNA		uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	54010	(01 40 4 001100400110	0 017.						
A	o,	icate be executed physician and s the burial-transit	Еха	resulting in death) Last	Due to	(or as a consequence	e of):						
	8760,	cate be chysici the bu	dical		l								
	Division of Vital Records, P.O. Box 6	To the Hospitel or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{yes} \) 2 No 9 \(\subseteq \subseteq \text{Unknown} \)	1 🗆 Live t	tcome of pregnancy birth 2 Tetal dea nant at time of death own		Ectopic pregnancy Other (specify)			23d.	Date of delin Month	very Day Year
	٦,	s that I ned by e deta	by Ph	Part II. Other significant conditions cor	tributing to d	eath but not resulting	in the u	nderlying cause give	n in Part I.	23e. Did t	obacco use d	ontribute to	the cause of death?
	ords	w requires that s been signed b should be deta	ted t	CONGESTIVE HEART I	-AiLURG	E, CORON	ARY	ARTERY	DISEASE	10	Yes 2□N	3 3 Pro	bably 4 □Unknown
	I Reco	ding Physician: The law r h. After this certificate has be funeral director, page 2 sh	Completed							24a. Was auto perfo 1 Yes	an 24 psy prmed2 20 No	4b. Were aut prior to c death? 1 ☐ Yes	copsy findings available ompletion of cause of
	Vita	sician; certific rector,	Be	25. Was case referred to medical examiner?	lospital:			Othe	26. Place of Death				
	of	g Phys er this eral di	n: To	27. Manner of Death		Inpatient 2 ER/C of Injury 28b th, Day Year)	. Time of	t 3 DOA 28c. Injury Work	4 Nursing Ho	ne 5 Resi 28d. Describe			ify)
	sion	death. ctor: Aft	atio	1 Natural 5 Pending investigation	(MOI)	III, Day real/	Injury		r ′es 2 □No				
	Divis	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place build	of Injury - At home, ing, etc. (Specify)	farm, str	eet, factory, office	:	28f. Location (City or To		ımber or Rui	ral Route Number,
		To the Hospitel or Attendir within 24 hours after death. To the Funerel Director: Al completely filled in by the fur	Medical Co	29a. Certifier 1 Certifying Phy (Check only one)	ner: On the b	e best of my knowled easis of examination a	ge, deatl and/or in	occurred at the time restigation, in my op	e, date and place, a inion, death occurr	and due to the ed at the time,	cause(s) and date and pla	manner as ce, and due	stated. to the cause(s)
_		To the within To the comple	Me	29b. Signature and title of certifier				29c. License	number		29d. Date sig	gned (Month	, Day, Year)
			1	Dr. Wal a	lane,	MD		P18	783		FEBRUA	ex 5	2005
		101		30. Name and address of person who co					-40 01	201			
		- Sta	ite	31. Date filed (Month, Day, Year)	32.4	ASTEN AVE		ALTIMORE	MD ZI	L-C4			
		Registi		FEB 0 9 20	05 A	lowe &	A	ne fi					

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State o	f Marylar		artmen rtificat				fental Hyg	iene	05	03961	
	Dhamisi		1. Decedent's Name (First, Middle	e, Last)							2. Date of Dea	th	Voor	3. Time of Death	
	Physici /Medio		Robert		Abraham						Februa	ry 3,	2005	1:45 A M	Ŋ
	Examir		4a. Facility Name (If not institution	-	mber)				Location			4c. Cour	nty of Death		
			212 Charmuth						ville		,			imore	
г	Funeral		5. Social Security Number 193–12–6062	6. Sex 1X□M 2□F	7. Age (In yrs. 79	• •	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Pay April 17,	1925		place (State or Foreigntry)	רון
L	Director		Usual Residence of Decedent		/9	110.					April 17,	1920	reni	őylvania	
	/land		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						1	IOd. Inside City Limits	s
	Man	tor	Maryland B	altimore		Luthe:	rvill	e						1 ☐ Yes 2X No	0
	r 28s	Irec	10e. Street and Number				10f. Zip				1	0g. Citizen o	of What Cour	ntry?	_
	within 72 hours after death with the Maryland ene. than "natural", or itama 23a or 28a-1 show I.a Madical Exaction or cust be multified at	Completed by Funeral Director	212 Charmuth R	oad				21	093			L	JSA		
	ama erra	ner	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U	.S. 13.	Was Deced	ent of His	spanic Ori	igin? (Spe	ecify Yes or No- Rican, etc.)		ace - Americ lack, White,		
36	or it	y Fu	1 Never Married 2 Marr	ned 1 Yes	2 □ No		1 ☐ Yes 2		Specify:		r noarr, oto.)	Spec		White	
8	ural',	d b	3 XWidowed 4 □ Divorced	Year or D	ates:										
21215-0036	"nat	lete	15. Deceden (Specify only highe	t's Education st grade completed)		16a. Deced	dent's Usua kind of wor DO NOT us	rk done d	uring mos	t of work	ing	16b. Kind of	Business/In	dustry	
12	within ene.	Jmc	Elementary/Secondary (0-12)	College (1	I-4or 5+)		hysic		,			Me	dical		
	filed Hygi Sthar		17. Father's Name (First, Middle,				19020		18. Mothe	r's Name	(First, Middle, I				
lan	id be ental ked o	To Be	David Abraha	m							et Auman				
Maryland	shou and M mar	-	19a. Informant's Name/Relations			19b. Mailin	ng Address	(Street a			A Route Number	City or Tow	m, State, Zip	Code)	_
	and 2 alth a 27 ls		Howard Abrah	nam/son		3 Da	amian	Cour	rt #2	2, R	osedale,	MD.	21237	7	
altimore,	of He of He litam		20a. Method of Disposition 1 Burial 2 Cremation	0 DD	20b. F	Place of Dispo	sition (Nan	ne of ther place	9)		Date	20c. Location	n - City or To	own, State	
Ĕ	Page nent ant: I		4 □Donation 5 □ Other (S		State	Jarzwal				02/1	7/2005	Exete	r Twns	ship, PA.	
alt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itama 23s or 28s-f show any injury or other traumatic event, it a Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee			. Name an							me, Inc.	
1050 York Road, Towson, Maryland 21204															
П			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the deat ach line.	h. Do not ente	er the mode	a of dying	, such as	cardiac c	or respiratory arm	est,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	a Co	rona	res (art	en	1 0	22	ease			Onset and Death	
	/Medical Examiner		resulting in death)	Due to	or as a conseq	uence of):	1	0	1	1-					_
П	Examine.	<u>.</u>	Sequentially list conditions,	b. Add	ult,	onse	1 6	20	abe	Le	2				
Т	led Isit	ulue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a conseq	uence or):									
	xecul and al-trar	Examiner	that initiated events resulting in death) Last	c	or as a conseq	uence of):									-
8760,	icate be executed physician and s the burial-transit														
687	ificate g phy as the	Physician/Medical		0.											_
Вох	The law requires that the death certific Ite has been signed by the attending p page 2 should be detached for use as	N/M	IF FEMALE: 23b. Was decedent pregnant		come of pregna							23d. D	ate of delive	ery	
	death e atte id for	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregn	irth 2□Feta ant at time of d]Ectopic pre] Other (spe					V	/onth	Day Year	
P.O.	at the de by the a tached	hys	9 🗆 Unknown	9□ Unkno	own										
	res tha iigned be de	by F	Part II. Other significant condition	ons contributing to de	eath but not res	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did tob	acco use co	ntribute to th	ne cause of death?	
ord	w require been si should I										1 🗆 Ye	s 2 No	3 Prob	ably 4 □Unknown	1
ecc	law ras be	ple									24a. Was a			psy findings available apletion of cause of	9
Vital Records,		Completed									perforn		death?	2□ No	
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?	-						of Death	(Check only on	3)			
	Physic this c	2	1 ☐ Yes ZXNo		npatient 2				4 🗆 140	rsing Hor		nce 6 🗆 O		()	
Division of	Attanding Physician: r death. sctor: After this certific by the funeral director,	lon	27. Manner of Ceath Natural 5 Pendin	9 .	h, Day Year)	28b. Time of Injury	M 28	3c. Injury Work			28d. Describe ho	w injury occi	urred		
<u>s</u>	or Attano after death Director: in by the	licat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	not be an Diese	of Injury - At ho	ome farm stre			'es 2 □ !	-	28f. Location (St	eet and Nun	nher or Rura	I Route Number	=
<u>S</u>	To the Hospital or Attanding within 24 hours after death. To the Funaral Director: After completely filled in by the funer	Certification:	4 Homicide determ	inea buildir	ng, etc. (Specify	y)	ot, ractory,	OHICE			City or Town		Der or Hura	r noute Number,	
	spita lours naral	al C	29a. Certifier 1X Certifyin	g Physician: To the	best of my kno	wledge, death	occurred a	at the time	a. date an	d place, a	and due to the ca	use(s) and n	nanner as st	ated.	_
	16 Ho 124 h 16 Fu Netely	edical	(Check only 2 Medical one)	Examiner: On the ba	asis of examination and stated.	tion and/or inv	estigation,	in my opi	inion, deat	th occurre	ed at the time, da	ite and place	, and due to	the cause(s)	
	withir To the comp	×	29b. Signature and title of certifier	12			29c.	License	number		25	d. Date sign	ed (Month,	Day, Year)	
	2		ptm W	1 Jow	re h:	1	D	120	64	9		217	120	005	
Ŧ	TIN		30. Name and address of person									-1 (1		-
_	J		John W. Bowie,			harles			uite	4902	Towsor	n, MD	21 204	+	
	Sta Registr	1	31. Date filed (Month, Day, Year)	1 0 2005	egistra s Signa	ture #	Spa	de							

Amend item f per fh g841 3-29-05 vt Jennifer H. Ashe Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a, PTT 27 28a-f. perME G840, 1.25.05 TT State of Maryland Department of Health and Mental Hygiene 05-0988 AKG 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** February 10:15 A^M Jennifer Holly Ashe /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Atlantic Ocean - 4 miles North of Route 611 Assateague Island Worcester 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Days Hours 1 □ M 2 🕅 F Director 24 Jan. 30, 1981 MD Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State item 27 is marked other than "neturel", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 X No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4255 Elsa Terrace Apt. 3 21211 USA Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No i and 2 should be filed within 72 hours after (lealth and Mantal Hygiene. im 27 is marked othar than "neturel; or Ite 1 ☐ Yes 2 If Yes, Give 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 File Clerk N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sandra J. Taylor ဥ Ralph R. Ashe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health ar Importent: If item 27 is any injury or other trat once. 731 Weil Mandel Way Hunt Valley, MD 21030 Sandra J. Taylor/Mother 20b. Place of Disposition (Name of cometery, crematory or other place)
Baltimore Washinton Date 20a. Method of Disposition Feb. 2005 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Laurel, MD Crematory 21. Signature of Funeral Service Litensee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Inc. Michael J. Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypothermia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Head and NEck Injuries Completed certificate has bean 24b. Were autopsy findings available prior to completion of cause of death?

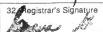
1 Yes 2 \(\subseteq \) No 24a. Was an autopsy performed? 2□No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: $_{4\,\square\,\text{Nursing Home}}$ 5 \square Residence 6 \square Other (Specify) at scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 XYes 2 No 2 this 28a. Date of Injury
Fnd (Month, Day Year)
2/7/2005 28b. Time of Fnd Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Hospitel or Attending Subject injured in motor vehicle accident and exposed to Natural 5 Pending 1 ☐ Yes 2XXNo investigation 7/2005 3e. · lace of Injury · At home, farm, street, factory, office building, etc. (Specify) 2XXAccident after deatr 6 Could not be determined Extrememental remember eratures 3 Suicide 4 - Homicide Assateague Island, Maryland 24 hours a Island 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only Uliel within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number OCME February 8, 2005

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)
FEB 1 0 2005



HA

111 Penn Street Baltimore, Maryland 21201

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No. 0 5 0 3 9 6 3)
			Reg. No: U U U U U U U U U U U U U U U U U U U	
ľ	Physici		Month Day Year	и
	/Medic Examin		Rena Mae Baker February 5, 2005 7:07P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
	Examin	e.		
	Funeral		Casey House Hospice Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 M 2 X F Yes Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country)	חו
	Director		223-32-9107 1 M 2 N F 81 Yrs. Months Days Hours Min. (Month, Day, Year) Country) July 5, 1923 Virginia	
	pu ,		Usual Residence of Decedent	
	aryla shov	-	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit	
	889-f	ecto	Virginia Page Luray ¹∆Yes 2□N	
	with 1	Ö	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	eath	Funeral Directo	179 Reservoir Avenue 22835 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian.	
	ter d	-un	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Usban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
98	urs al	by	3X Widowed 4 □ Divorced Vegror Dates: Specify: Specify: Specify:	
21215-0036	filed within 72 hours after death with the Maryland Hygiene ther then "neturel", or Hems 23e or 28e-f show ant, the Madical Exstitution at the multiplian	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry	_
215	thin 7 e. en "n Med	ple	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	
2	filed wil Hygien sther th	Con	9 Homemaker Own Home	
ם	be filed within 72 hours after death with the Marylan tal Hygiene. d other then "neturel", or liems 23e or 28e-f show event, Ire Madical Executer or cities and	Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
Maryland		2	Claude Allen Miller Maude Mae Fox	
<u>la</u>	2 short and Ism		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
	s 1 and 2 should f Health and Mer Item 27 is marke other treumetic		Frances Parise / Daughter 8109 Irwell Court, Gaithersburg, MD 20877 20a. Method of Disposition (Name of Disposition (Name of Disposition Court) 20b. Place of Disposition (Name of Disposition Court)	
وّ	m 0 .		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Morning Star	
Baltimore,	it. Partmer rtent righty		'4 Donation 5 Other (Specify) Lutheran Cemetery Feb. 10, 2005 Luray, VA 21. Signature of Funeral Service Licensee #CC 0321 22. Name and Address of Facility The Fradley Funeral Home, Inc.	
Ba	permit. Page Department of Importent; If any injury or once.		Manual Destate 187 E. Main St., Luray, VA 22835	
		-	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate	
١.	Dharatatan		Immediate Cause (Final Onset and Death	
	Physician /Medical		disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of):	
	Examiner			
F		ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
/	ocuted nd transi	Examiner	cause. Enter Underlying Cause [Liseass or injury that initiated events c.	
Ö,	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of):	
8/60	ate Se	dical	d	
×	eath certific attending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	
ROX	atter for u	clan	230. Was december pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy	10
o.	y the	Physiclan/Med	1 ☐ Yes 2 No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	
<u>.</u>	that	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	
Kecords,	w requires that the de been signed by the should be detached		Cerebrovascular Accident 1 Tes 2 No 3 Probably 4 Unknown	i
ပ္သ	law re as bee 2 sho	ompleted	24a. Was an 24b. Were autopsy findings available	3
	0 - 0	E O	autopsy prior to completion of cause of performed? death? 1 □ Yes 2♥ No 1 □ Yes 2 □ No	
VItal	ysicien: Th is certificate director, pag	Be C	25. Was case referred to medical 26 Place of Death (Check only one)	-
-	di d	10	examiner? 1 Yes 2X No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 XOther (Specify) Hospice	
0	ng Pl		27. Manner of Death 1	
<u> </u>	tendi leath. tor: A the fu	catl	2 Accident investigation M 1 Yes 2 No	
DIVISION	or At after of Direction by	Certification:	Suitclas Sui	
	ppitel ours s werel filled	Ö	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	-
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only one) Check only one Che	
	To th Within To th comp	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
			BR 4216114 February 5, 2005	
	<u>.</u> [30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
	4		Chitra Rajagopal, MD, 9715 Medical Center Dr., #221, Rockville, MD 20850	
	Sta		31. Date filed (Month, Day, Year) FEB 1 0 2005 Registrar's Signature	
	Registr	ar .	FEB 1 0 2005 Reduce to position	

			1 For State	State of Maryland	/ Department of Health and	Mental Hygier	ne					
			Registrar 1. Decedent's Name (First, Middle, La	ist)	Certificate of Death	Reg. I	3. Time of Death					
	Physici /Medio		KOSA		BROOKS	FE bushy	05 2005 4-50 AM					
	Examin	er	4a. Facility Name (If not institution, give	e street and number)	4b City, Town, or Location of De	ath	4c. County of Death					
	Funeral	۸	5. Social Security Number 6. S	Sex 7. Age (In yrs. last	birthday) Munder 1 Year If Under 24 H Yrs. Months Days Hours Mi		9. Birthplace (State or Foreign Country)					
	Director	W	Usual Residence of Decedent			10-23-5	3 Maryland					
	Marylar f show	or	10a. State 10b. County	10c. City, T	own or Location		10d. Inside City Limits 1 ★Yes 2 □ No					
	or 28a	Olrect	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Country?					
	death with the Maryland ms 23s or 28s-f show rivest be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - American Indian,					
36	s after o	y Fun	1 Never Married 2 Marned	Armed Forces? 1 ☐ Yes 2 No If Yes, Give	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 No Specify:	erto Rican, etc.)	Black, White, etc.					
21215-0036	72 hours after natural', or Ita Jical Exacili e	ted by	3 Widowed 4 □ Divorced 15. Decedent's E	Year or Dates:	6a. Decedent's Usual Occupation	16b.	Kind of Business/Industry					
121	within 7 iene. than "r	Completed	(Specify only highest gra	College (1-4or 5+)	(Give kind of work done during most of w life. DO NOT use retired)	norking M						
	be filed stat Hygie of other avent, ti	To Be Co	17. Father's Name (First, Middle, Last)	18. Nother's N	ame (First, Middle, Maid	en Sumame)					
Maryland	should b nd Ments marked umatic a		Thessie Br	Type Bright A	Rosc	2 Yvonn	e Stovall					
_	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28a-f show any injury or other traumatic avent, the Marical Executive Last be reciliad at once.	-	Salena Tuc	Ker (Daughter)	9b. Mailing Address (Street and Number or a 27 Tradewon)	Crcle B	160.MD 21030					
Baltimore,	ages 1 nt of He t: ff itar / or oth		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	e of Disposition (Name of etery, crematory or other place)	Date 20c.	Location - City or Town, State					
altin	permit. Pag Department Important: I any injury o		* 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lices	UICO	NAOUNT PENASTON	48/05 1	240.MD					
<u> </u>	8 9 E 8		Gue W.	Theations that coursed the death. F	5151 Balto Na Do not enter the mode of dying, such as cardi	hours fike	,2+.40, Balto NO					
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	to not enter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between Onset and Death					
	/Medical Examiner	Completed by Physiclan/Medical Examiner	resulting in death)	a. Due to (or as a consequence	ce of):		- YEARS					
1				b. Due to for as a consucular	6 JUAKS							
	cate be executed physician and the burial-transit		Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence								
8760,	ate be executed hysician and the burial-transit			_ d								
9	certifica Iding ph				siclan/Med	siclan/Med	IF FEMALE:	23c. If yes, outcome of pregnancy			201 0 1 1 1 1	
Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as						siclar	siclar	siclar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	
P.0.	that the ed by th detach				9 ☐ Unknown Part II. Other significant conditions of		g in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?			
Vital Records,	en sign				RENAL Failure	1 0 1	stimal Bleeding		2 ☑ No 3 ☐ Probably 4 ☐ Unknown			
3ecc	e law re has be je 2 sho	mplet				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of					
tal		0	25. Was case referred to medical		26 Place of Di	performed 1 Yes 2 N eath (Check only one)	death? 1 Yes 2 No					
	Phyaici this cer ral direc	To B	examiner? 1 Yes 2 No		Outpatient 3 DOA Other: 4 Nursing	Home 5 Residence						
ion	nding P th. :: After e funera	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	D. Time of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred					
Division of	Hospital or Attandi 24 hours after death. Funaral Diractor: A tely filled in by the t	Certification:	3 Suicide 6 Could not be determined		farm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)					
	spital of nours all naral D	al Ce	29a. Certifier 1 Certifying Ph	ysicien: To the best of my knowled	dge, death occurred at the time, date and place	e, and due to the cause(s) and manner as stated					
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medicel Exergine) 29b. Signature and title of certifier	and manner stated.	and/or investigation, in my opinion, death occ	curred at the time, date a	nd place, and due to the cause(s)					
}	T wit		250. Signature and title of certifier	1	29c. License number	29d. D	ate signed (Month, Day, Year)					
	B		30. Name and address of person who	completed cause of death (Item 23a	29c. License number ROS - 000 a) (Type, Print) OUFE St. BALLINOUS Aparles	- M	1 1 2 1211					
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	THE ST. BALLIMON	E, MARY	1ANG C/C8/					
	Registr		FEB 1 0 2	2005 Receive D	! Sparle							

		•	State of Maryland / Department of Health and I 1- State Registrar Certificate of Death		ene 2005 03965
	Physici		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day 8 2005 135 P M
	/Medio Examir		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Sykesville	h	4c. County of Death
	Funeral Director		5. Social Security Number 5. Sex 1 M XIXF 7. Age (In yrs. last birthday) 85 Yrs. Wonths Days Hours Min.	8. Date of Birth (Month, Day,) July 23	(ear) 9. Birthplace (State or Foreign Country) Maryland
	aryland show	_	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes ¥☑ No
	the Ma	Director	MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code	100	g. Citizen of What Country?
	3a or	0	301 Northway Court 21136		U.S.A.
36	s 1 end 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, Itam 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Exeminating the motified at	Completed by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married XX Married 1 Never Married XX Married 1 Never Married X Married 1 Never Married X Married 1 Never Married 1 Nev	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
215-0036	nn 72 hou n "natura Wedical E	pieted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+)		Sb. Kind of Business/Industry
2121	ed with	Com	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker		Own Home
Maryland	utd be fill Mental Hy irked oth	To Be	Charles W. Marsh Charles W. Marsh Ruth	me (First, Middle, Ma Britting	ham
/an	2 sho and ? Is me	3 1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Re		
	of Health of Health of Health of Health other tree		Raymond J. Burris/Spouse 301 Northway Court 20a. Method of Disposition 20b. Place of Disposition (Name of		Oc. Location - City or Town, State
JOE L	Pages nent of int: If it iry or o		**************************************	12/05 R	eisterstown,MD
Baltimore,	permit. Pages 1 Department of H Important: If ital any injury or ott		21. Signature Funeral 5 Tvice Licens 22. Name and Address of Facility EC	khardt F	uneral Chapel P.A. rings Mills,MD21117
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiar shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	c or respiratory arres	st, Approximate Interval Between Onset and Death
	Examiner				/
,8760,	ate be executed thysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
O. Box 6	death certific e attending p ed for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 1 yes 2 1 1 yes 2 1 1 yes 2 1 1 yes 2 1 1 yes 2 1 1 yes 2 1 1 yes 2 1 1 yes 2 1 1 yes 2 1 1 yes 2 1 1 yes 2 1 1 yes 2 1 1 yes 2 1 1 yes 2 1 1 yes 2 1 1 yes 2 1 1 yes 2 1 1 yes 2 1 yes 0 yes 0 1 yes 0 1 yes 0 1 yes 0 1 yes 0 1 yes 0 1 yes 0 1 yes 0 1 yes 0 1 yes 0 1 yes 0 1 yes 0 1 yes 0 1 yes 0 yes 0 1 yes 0 1 yes 0 1 yes 0 1 yes 0 1 yes 0 1 yes 0 1 yes 0 1 yes 0 1 yes 0 1 yes 0 1 yes 0 1 yes 0 1 yes 0 y		23d. Date of delivery Month Day Year
rds, P	luires that n signed b	d by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba 1 ☐ Yes	acco use contribute to the cause of death? 2 170 3 17 Probably 4 17 Unknown
of Vital Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed by	Ofeoarthritis	24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
/ital		BeC	© 25. Was case referred to medical 26. Place of Dec	ath (Check only one))
on of V	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	2	Plant 1 Inpatient 2 ER/Outpatient 3 DOA Osher: William Housing H	Home 5 Resident 28d. Describe how	ice 6 □Other (Specify) v injury occurred
Division	al or Atters all or Atters after dea	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	set and Number or Rural Route Number, State)
	n 24 hour n 24 hour ne Funera	Medical C	29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one)		
	To the To the Comp	×	29b. Signature and title of centifier 29c. License number	290	d. Date signed (Month, Day, Year)
•	.01		Melle y ll ms 0005813	2	2/9/05
	H		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Willow Kus 295 Stoner Are St. 307	Westmin	stor MD 21157
	Sta Regist	ate rar	A O COOF MAN TO COOK		

			For State Registrer		Marylan		artment of H			R	leg. No. 2 (005	03966
f	Physici /Medic	al	1. Decedent's Name (First, Middle Robert			Bul		-1	F	2. Date of Dea Month EBRUAL	Day 5	Year 2005	3. Time of Death 0 300 ₼ M
	Examin	er	4a. Facility Name (If not institution,			nton	4b. City, Town, or			•	4c. Coun	ty of Death	N/A
	Funeral		Stella Maris - 5. Social Security Number	6. Sex 7		last birthday)	If Under 1 Year	If Under 2	timor	B. Date of Birth (Month, Day	1	9. Birthpi	lace (State or Foreign
В	Director		205-12-6063	1 X M 2□ F	87	7 Yrs.	Months Days	Hours		Month, Day, June 17,		PA.	try)
	and w		Usual Residence of Decedent 10a. State 10b. County		10c, Cit	y, Town or Lo	cation					10	Od, Inside City Limits
	Maryii f sho ied s	or	MD. Balti	more		Dunda							1 ☐ Yes 2 [XNo
	r 28a	rect	10e. Street and Number	more.		Duria	10f. Zip Code			1	l0g. Cîtîzen o	f What Coun	try?
	th with	Funerai Director	1904 Harrison R	load			2122	2			US	SA	
	r dea	ner	11. Marital Status	12. Was Deceder Armed Force	s?	S. 13.	Was Decedent of H	lispanic Orig	gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)		ace - America	
36	s afte	by Fu	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 Tyes 2 f If Yes, Give 4 Year or Date:			1 ☐ Yes 2 🎇 No	Specify:			Spec	ify:Whit	е
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Items 28s or 28e-f show the Maciral Examinar must be notified at	ted t	15. Decedent	s Education	s.	16a. Dece	dent's Usual Occup	ation			16b. Kind of	Business/Ind	lustry
215	hin 7; e, en "na Medi	pie	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4c	or 5+)	(Give	kind of work done of DO NOT use retired	during most d)	t of working	7			
2	ygien ygien rer th	Completed	8 years			Mech	nanic					need M	artin
Maryland	be fill ad ott	Be	17. Father's Name (First, Middle, I	_ast)						First, Middle,	Maiden Suma	ume)	
7	should nd Mei mark matic	은	Michael Bulko 19a. Informant's Name/Relationsh	nio (Type, Print)		19b. Mailir	ng Address (Street			Bulko	r. City or Tow	n, State, Zip	Code)
Z	nd 2 s lith an 27 is r trau		Lula Bulko	wife			Harrison						,
Je,	s 1 ar		20a. Method of Disposition			lace of Dispo	sition (Name of matory or other place	ce) T	Februa	te arv	20c. Location	- City or To	wn, State
Ē	Page nent c ant: If ury or		1 ☐ Burial 2 🌠 Cremation 1 ☐ Donation 5 ☐ Other (Sp.	3 ∐Removal from Sta necify)	TA I		Crematory		3, 200		Baltimo	ore Ci	ty, MD.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene I propriett If item 27 is marked other than "natural", or Items 28s. or 28s-f show any injury or other traumatic event. Ite Mcdiral Examinar must be notified at once.		2 Sign Ture of Funeral Service L	el h			Name and Address Connelly I 7110 Solle	Funera ers Po	al Hor	me Of I	Dundalk Dundalk	P.A.	21222
	Physician		23a. Part1. Enter the disease, or shock or heart failure. List of limited at Cause (Final disease or condition resulting in death)		ed the death line.	n. Do not ent	er the mode of dyin	g, such as o	cardiac or i	respiratory arr	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		Sequentially list conditions.	Due to (or a									
1/	ped isit	if a	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury										
×.	death certificate be executed e attending physician and ad for use as the burial-transit	Exar	that initiated events resulting in death) Last	c Due to (or a	as a consequ	uence of):							
8760,	ate be nysicia he buri	call		C:									
89	intifica ing ph	Medi	IF FEMALE:	1							1	1	
Вох	death certific attending pl	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon	2 Fetal	death 3	Ectopic pregnancy	,				ate of deliver	ry Day Year
0	that the de ed by the a detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		eath 5L	Other (specify)						
ds, P.	es pe pe	by	Part II. Other significant condition	ns contributing to death	but not resu	ulting in the u	nderlying cause give	en in Part I.			bacco use cor	ntribute to the	e cause of death?
Records,	w requir been sl should	Completed	Chasei	c obstice	to the	Pul	1. 6710.4.	die	20.1	24a. Was a	n 24b	. Were autop	osy findings available
Re	he iav le has age 2	ошо	CWUJIM	033-100	. V LUC		()	4174	00	autops perform	ned?	prior to con death?	npletion of cause of 2 No
	ician: Th certificate rector, pag	a	25. Was case referred to medical					26. Place	of Death (Check only on		10100	20110
	ding Physician: The n. After this certificate hitteneral director, page	To B	examiner? 1 🗆 Yes 2 🔽 No	Hospital: 1 ☐ Inpa	atient 2 🗆	ER/Outpatier	nt 3□ DOA Othe	er: 4 🗌 Nur	rsing Home	5 Reside	ence 6	ther (Specify)
n of	ding PI n. After ti funera	:uo	27. Manner of Death 1 Natural 5 □ Pending		njury Day Yea <i>r)</i>	28b. Time of Injury	Worl		1	d. Describe ho	ow injury occu	irred	
isio	r Attendi er death. rector: A by the fi	Icati	2 Accident investig	ot be	Injuny - At ho	me form etr	M 1 []	Yes 2□N		f Location (Si	treet and Num	ber or Rural	Route Number,
Division	after after Direction by	Certification:	4 Homicide determi	ned building,	etc. (Specify	()	eet, factory, office		20	City or Town		ibor or rioral	riouto i tamber,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	edicai C		g Physician: To the be examiner: On the basis and manner	of examinal								
	To th within To th compl	Me	29b. Signature and title of certifier	1/~			29c. License	e number	_	2	9d. Date sign	ed (Month, E	Day, Year)
			Mous	las la	Qu	W	DC	1/9	30		lebr.	vary	7,2005
	10		30. Name and address of poston v	vho completed cause o	f death (Item		Print) 301	St.	Pov	1 Pla	Co	O	
			31. Date filed (Month, Day, Year)	1 (Z () /	MAN / strar's Signa	MO	150	17	wor	e, ma	212	07	
	Sta Registr		No.	005 Below	a d	doe	W)						

BULKO, ROBERT

		1	State of Maryland / Department	artment of Health and M rtificate of Death	lental Hygie Reg.	4000	03967
	Dhysiei		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al -	Annabell Wunderle Bledsoe	d. Cit. To and antica of Double		2005 Year	10:35a [™]
	Examin	er	ta. Facility Name (If not institution, give street and number) Vantage House	4b. City, Town, or Location of Death Columbia		4c. County of Death Howard	
	Funeral		5. Social Security Number 6. Sex T 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Ye August 14	9. Birthp	lace (State or Foreign
	Director		200-12-8431 1 M 2 F 85 Yrs.	Months Days Hours Min.	August 14	,1919 Per	nnsylvania
	and **	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Live				0d. Inside City Limits
	Maryl -f sho	to	Maryland Howard Columbi	a			1 ☐ Yes 2 ☐XNo
	th the or 28a e roll	irec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	ntry?
	ath wi	by Funeral Director	5400 Vantage Point Road #411	21044		USA	and the distance of the distan
	iteme	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 Married 1 □ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Americ Black, White,	
920	urs af	by F	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 💹 No Specify:		Specify: Whit	te
21215-0036	be filed within 72 hours after death with the Maryland stal Hyglene. So other than "natural", or iteme 23a or 28a-f show event. The Medical Evanirat must be notified at	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki	ing 16t	. Kind of Business/In	dustry
121	within ane. than '	ldmo	Elementary/Secondary (0-12) College (1-4or 5+)	po NOT use retired) rence Librarian	F	ublic Lib	carv
d 2	filed Hygie other		17. Father's Name (First, Middle, Last)		(First, Middle, Mai		ary
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, Ite Ma	To Be	Frederick Valentine Wunderle	Hester	Rodenbaug	gh	
lary	s 1 and 2 should f Health and Men item 27 is marke other treumatic			ng Address (Street and Number or Rura			
	1 and Health em 27 ther tr		7 3	Maternal Gift Dri		Location - City or To	
nor	Pages nent of I int: If ite		Burial 2 M Cremation 3 L Hemoval from State	matory or other place) matory Inc. 02/09		ltimore, l	
Baltimore,	구두라는		21 Signature of Funeral Service Licensee	2. Name and Address of Facility			
m	Depar Impo any ir		Thomas Gregor)	remation Society 0 99 Frederick Road	Baltimore	d Inc. Maryland	1 21228
П	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between Onset and Death
			Immediate Cause (Final disease or condition resulting in death)	Mysminy			Luks
		ner	Due to (or as a consequence 1):	Perteron			in
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	-1.1			0
J	ecuted and transi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	- porture		1	ys .
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	al E	bus to (yr as a consequence on).	v			
687	ficate g phys	edical	d				
Box	h certi	M/us	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	⊒Ectopic pregnancy		23d. Date of delive	
	that the death certificed by the attending properties as	Physician/M		Other (specify)		Month	Day Year
P.0	that the	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to t	ne cause of death?
ds	quires that n signed t	d b	Rend insuffering		1 ☐ Yes	2 No 3 Prob	pably 4 Unknown
Records,	aw requir is been si 2 should I	Completed by	, , , , , , , , , , , , , , , , , , , ,		24a. Was an autopsy	24b. Were auto	psy findings available moletion of cause of
R		Com			performed 1 ☐ Yes 2	i? death? No 1 ☐ Yes	mpletion of cause of 2□ No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? Hospital:	Other **	h (Check only one)		
of	Phys	. To	27. Manner of Death 28a. Date of Injury 28b. Time	att 3 DOA 4 A Nursing Ho	me 5 Residence 28d. Describe how i	e 6 ⊡Other (Specifinjury occurred	ý)
ion	Attending For death. ector: After by the funer	ation	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division of	r Attendi	tifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura State)	al Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Certification;	29a. Certifier 15 Certifying Physicien: To the best of my knowledge, dea	th occurred at the time, data and al	and due to the same	a/s) and manner as	tated
	Hospitei 24 hours a Funerei etely filled	dica	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, dea 2 Medical Exeminer: On the basis of examination and/or i and manner stated.				
	To the within 2 To the comple	Me	29b. Signature and tele of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
			XXXILLETT IS	1)-34868	Uc	1-08/03	7
	15		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) to Parle	Catush.	A MAIN	Aruli
	Sta	ite.	31. Date filed (Month, Day, Cap.) 7 20032. Registary Signature	freels)	- 400 (01)	1 000)	17
	Regist		LED I A SAMO NORMED YOU	The same of the sa			

			1- State of Maryland / Dep 2)17/05 reb Registrar Amend item 19b/info.G-840	artment of Health and Mertificate of Death		enez 0 0 5	03968	
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death	
	/Medic		Estelle	Barr	FEBRUARY	75, 2005	7:40A. M	
	Examir	er	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1	
-			2406 LAURETTA AVE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	BALTIMORE If Under 1 Year If Under 24 Hrs.	0.0			
	Funeral Director		225-36-5331 1 M 2 M F 74 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y 10 06	(ear) 9. Birth	nplace (State or Foreign untry) VA	
	ס		Usual Residence of Decedent		10 00	30	VA	
	arylar show	_	10a. State 10b. County 10c. City, Town or L				10d. Inside City Limits	
	Ba-f	Director	MD NA Baltim				XX es 2 □ No	
	with t		10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	intry?	
	ne 23	Funeral	2406 Lauretta Ave 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe	cify Ves or No-	U.S.A.	ican Indian	
9	within 72 hours after death with the Maryland ene. then "natural", or Itame 23a or 28a-f show ha Madical Examinar must be rollibul at		1 Never Married 2 Married 1 Vec 20 No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White	, etc.	
8	ral',	d by	3 Vidowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🗹 No Specify:		Specify: B	lack	
5-("natu	iete	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of workir DO NOT use retired)	16	b. Kind of Business/I	ndustry	
21215-0036	withir ene. then	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)	Housewife		Home		
D D	filled Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Mai			
Maryland	Aenta Aenta rked tic ev	To B	Shelton Pendleton	Nannie	Lou Smi	th		
lary	2 sho and A Is ma			ng Address (Street and Number or Rura				
≥,′≤	and ealth m 27 her tr		5506	• Plainfield Av		imore, M	d 21206	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healin and Mental Hygiene. Department of Healin and Mental Hygiene. Department of Healin and Mental Hygiene and any injerter of Hame 23a or 28a-1 show any injerter of the recomple avent, the Medical Examination at codified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	matory or other place)		c. Location - City or T	own, State	
量	it. Pa intmer intent njury			n Cemetery 2/10,	/05 B	alto Co,	Md	
Ba	permi Depa Impo any it		Monald & Thught 4	arch for West 300 Wabash Ave,			21215	
			23a. /art1. Enter the disease, or complications that caused the deeth. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between	
Z	Pnysician /Medical		d sease or condition resulting in death) a. How to work a few few few few few few few few few few	urosclentie Condion	usculan	Lucare	Onset and Death	
	Examiner		DA to (or as a consequence of):					
		Jer	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying					
1/	cuted hd ransit	Examiner	Cause (Disease or injury that initiated events c.					
, ,	e exe sian ar urial-t	EX	resulting in death) Last Due to (or as a consequence of):					
68760,	icate be executed physician and the burial-transit	dicai	d					
		/Me	IF FEMALE: 23c. If yes, outcome of pregnancy					
ñ	death certiff e attending od for use as	Physician/Me	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv Month	ery Day Year	
о. О	0 0 0	hysi	9 Unknown					
S, T	law requires that the as been signed by the 2 should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to t	he cause of death?	
ord	w require been si should I				1 🗆 Yes	2 No 3 Prot	pably 4 Unknown	
Records,	e law r has be	Completed			24a. Was an autopsy	24b. Were auto	ppsy findings available mpletion of cause of	
	Th ate	Cou			performed	? death?		
<u> </u>	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death				
Division of Vital	Phys r this aral dii	. To	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatier 27. Magner of Death 28a. Date of Injury 28b. Time o	1 3 DOA 4 Nursing Hom	e 5 Residence	e 6 Other (Special	y) SCENE	
lon	nding Ph ath. :: After th e funeral	atior	1 ∰Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		injury coodinou		
VIS	or Attending after death. Director: After in by the fune	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, (arm, str building, etc. (Specify)	reet, factory, office	3f. Location (Street	t and Number or Rura	al Route Number,	
٥	Itel or rrs afte rel Diu led in	Cer	Building, etc. (Specify)		City or Town, Si	rare)		
	To the Hospitel or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fur	Medical	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death 2. Medical Exeminer: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, ar vestigation, in my opinion, death occurred	nd due to the cause d at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)	
	To the comp	M	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)	
)			X VXVX	O.C.M.E.	FE	BRUARY 5,2	2005	
	3		30. Name and address of person who completed dause of death (Item 23a) (Type,	,				
	Stat	te	31. Date filed (Month, Day, Year) 32. Regignar's Signature	111 PENN STREET BA	TTTIIOKE,	MAKILAND Z	1201	
	Registra		FEB 1 0 2005 Harry &	docie				

			For State Registrar	State of Marylan		rtment of F			giene 2 (105	03969
	Physici		1. Decedent's Name (First, Middle, Last)	L Brawner				2. Date of Dea Feb 2,	ath	Year	3. Time of Death 8:25 A M
>	/Medic Examir		4a. Facility Name (If not institution, give s Southern Marylan			4b. City, Town, o			4c. County Prin	of Death	orge's
	Funeral Director		5. Social Security Number 6. Sex 577 58 2917	7. Age (In yrs. I	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days		lin. 8. Date of Birt (Month, Da Feb 4,	y, Year)	Country	e (State or Foreign ngton DC
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itams 23a or 28a-f ahow any injury or other traumatic event, I'm Medical Eriar if actinisal to multified at Once.	by Funeral Director	Maryland Prince (10e. Street and Number 6704 Spring	George's	T	10f. Zip Code	0735 dispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	Blac	What Country States e - American ck, White, etc.	S Indian,
Maryland 21215-0036	filed within 72 hours Hygiene. other than "natural", ent, tre Medical E.u.	Completed	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade 15. Decedent (Specify only highest grade 15. Decedent (Specify only highest grade 15. Decedent (Specify only highest grade 15. Decedent (Specify only hi	Year or Dates:	16a. Deced (Give life. L	lent's Usual Occup kind of work done DO NOT use retired Urement (pation during most of d) Officer	working Name (First, Middle,	Specify 16b. Kind of Bu Governm Maiden Suman	usiness/Indus	
rylan	hould be d Mental marked c matic eve	To Be	John William		10h Mailie	a Address (Street		aret Dyer	City of Town	Chara Tip Co	
, Ma	and 2 sl ealth and n 27 ls r		19a. Informant's Name/Relationship (Ty) Eda Brawner (Wife)		6704	Springb	rook La	Rural Route Number ne, Clinte	on, Mary	land 2	20735
Baltimore,	Pages 1 ment of H ant: If Ite ury or oth		20a. Method of Disposition 1	emoval from State 20b. P	inity	sition (Name of natory or other plac Memorial	Garden		20c. Location - Valdorf,	Mary.	land
Balt	Depart Depart Import any inj		21. Signature of Funeral Service License	- MO1422	_ A1	exandria	Ferry :	ee Funeral Rd, Clinto	on, Mary		
8760,	Cate be executed hydrogram and prize transit the british transit trans	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, leading to mimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to	uence of):	le to	-	nac or respiratory an	iosi,	In	pproximate terval Between nset and Death
O. Box 6	ne death certification the attending I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	1		23d. Dat Mo	te of delivery nth Da	ay Year
rds, P.	quires that the signed by aid be detacted	by	Part II. Other significant conditions con	tributing to death but not resu	ulting in the ur	derlying cause giv	en in Part I.		obacco use control		cause of death?
		Completed	lisean						rmed?	Were autopsy prior to comp death? i Yes 2[findings available letion of cause of
	sician certifi rector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 255No.	ospital:	D(0.4	Oth	06	Death (Check only o			
Division of	ding Ph J. After th funeral	F :	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	R/Outpatien 28b. Time of Injury	28c. Injun	y at	g Home 5 🗌 Resid 28d. Describe h	ow injury occurr		
Divis	ital or Atten rs after deatl al Director: ed in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		28f. Location (S City or Tow	Street and Numb m, State)	er or Rural R	oute Number,
	To the Hospital or Ai within 24 hours after of To the Funeral Direc completely filled in by	edical	(Check only	ician: To the best of my knowner: On the basis of examinat and manner stated.	wiedge, death ion and/or inv	estigation, in my o	pinion, death or	ccurred at the time, o	date and place,	and due to th	e cause(s)
	To the within 3 To the comple	W	29b. Signature and title of centrer	co MI	7	29c. Licens	e number	57	29d. Date signed	Month, Day	y, Year)
n	111		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print) 9/	3/ 8	7324	CF 12-		18
1)1 '		Keré Gra	ca mi	7	C1.	nter	2 , 12		20.	735
	Sta Registr	- 1	31. Date filed (Month, Par Year) 20	32. Registrar's Signat	ture A	parti					

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event. The Medical Examinat must be notified at once. Baltimore, Maryland 21215-0036 Baran, Andrew Physician /Medical **Examiner** To the Hospital or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

FEB 1 0 2005

	_		ertificate of Death	Reg. I	2005 02070
siciar	1	1. Decedent's Name (First, Middle, Last)			Day Year 3. Time of Death
edica mine		ANDREW BARAN 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	February	5 2005 309 PM
		Franklin Square Hospital center	Rosedale	1	Baltimore
ral or		5. Social Security Number 216-05-3786 Usual Residence of Decedent 6. Sex 156 M 2 F 88 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 4/5/16	O Diebeless (Christian Courter
		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	j j		IMORE		1 X Yes 2 □ No
2	חוב	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	ela	4011 CHESTERFIELD AVE. 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Historia Origin? (See	ority Vac or No-	USA 14. Race - American Indian,
1	5	1 Never Married 2 Married 1 Married 2 No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
1	λα r	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates: WW II	1 ☐ Yes 2 🔀 No Specify:		Specify: WHITE
	ere	15. Decedent's Education 16a. Deci (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired)	ng 16b.	Kind of Business/Industry
	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	TAILOR	i	MILITARY
0	Se l	17. Father's Name (First, Middle, Last)		(First, Middle, Maid	
	0	FRANCIS BARAN			BIEDRONSKI
			ing Address (Street and Number or Rura 3 DEERBORN DR.		
	j	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, cre	osition (Name of practice)	ate 20c.	Location - City or Town, State
		`4 □Donation 5 □Other (Specify) HOLY RO	SARY CEME. 2/9/		NDALK , MD.
once.			ACZURÓWSKT ^{aci} PUNE 201 DUNDALK AVE		P.A. MORE, MD. 21222
		23a. Part1. Enter the disease, or combications that caused the death. Do not er shock, or heart failure. List only one cause on each line.			Approximate Interval Between
an i		Immediate Cause (Final disease or condition resulting in death) a. COFONARY A	rtery Diseas	se	Onset and Death
er		Due to (or as a constituence of):			
i i	2	Sequentially list conditions, if any, leading to immediate cause. Enter Underflying Cause (Disease or injury	leart tailur	2	5 years
E C	Evalille	that initiated events	enal Insuff	icienc	y 15 years
ú	i i	resulting in death) Last Due to (or as a consequence of):			
i i	ברים ברים ברים	d			
2/W/c	N/A	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	7-		23d. Date of delivery
London Madical	31010	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		Month Day Year
P.		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
Ī	2				2 No 3 Probably 4 Unknown
plate	בובו			24a. Was an	24b. Were autopsy findings available
2	5			autopsy performed?	
a	מ	25. Was case referred to medical examiner?	26. Place of Death	Check onl one	
ļ.	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of		ne 5 Residence	
2		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	od. Describe now [ri	jury occurred
rtific		3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	8f. Location (Street: City or Town, Sta	and Number or Rural Route Number, ate)
Modical Cortification:	calcal	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dear 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the cause ad at the time, date a	(s) and manner as stated. Ind place, and due to the cause(s)
2	2	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
		ommen, mo	D006/062		02/06/2005
)+l		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	10 D-11	timore MD 21237
State		DR Jonerthan Hansen 900 Fran 31. Date filed (Month, Day, Year) 32. Restrar's Signature Low	Rangel Uri	ve Balt	rimore MU CIEST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

Physicia /Medic **Examin**

Funeral Director

Marie Co

State of Maryland / Department of Health and Mental Hygien® 03971 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Patricia Buzgierski 2005 February 5:15 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 706 S. 51st Street Dundalk Baltimore County 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 XXF Director 215-44-0224 58 Yrs. 1946 Aug. 11 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 27 is merked other than "naturel", or liems 23e or 28e-f show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Maryland Baltimore County Dunda1k 1 ☐ Yes 2 X No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 706 S. 51st Street 21224 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 200 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other than "naturel", or Iter 1 Never Married 2 Married 1 ☐ Yes X2X☐ No Specify: white 3.XXVidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In own home 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Austin R. North, Sr. Mary Elizabeth Herman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr any injury or other traurr <u>once</u>. Otto Geisbert, Jr. Son 706 S. 51st Street Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State Sacred Heart of Jesus 2/9/05 XXBurial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland Funeral Service Licensee 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** トイクラ Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1etastases Blau Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ed by the attended for us 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑No 9☐ Unknown 9 TUnknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 🗌 No 3 🔲 Probably 4 🗌 Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1□ Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certified Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 ☐ Yes 2 No 3□ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Aatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier my 51 c --29c. License number 29d. Date signed (Month, Day, Year) Sant az 107/01= 17/12 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bash 2112 Dun Jant a Seeth WINKS 31. Date filed (Month, Day, Year 32. Register's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 7 per fh 9840 2-10-05 vt State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death 2. Date of Death Day 2 1. Decedent's Name (First, Middle, Last) Year **Physician** FEBRUARY 2005 2:15 A M /Medical 4c. County of Death 4a. Fecility Name (If not institution give street and number) 4b. City, Town, or Location of Death Examiner BON SECOURS -TIMORE HOSPILAL BAL N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. AUG. 2, 1952 (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1₩ M 2□F MARYLAND - Yrs 214 64 8202 **Director** Usual Residence of Decedent with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at TY Yes 2 □ No MD N/A BALTIMORE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 1603 Mc HENRY ST. U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) LABORER SHIPYARD BETHLEHEM STEEL CO. other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 90 . Pages 1 and 2 should be tment of Health and Menta tant: If Item 27 Is marked WALTER BAILEY MARTHA EURE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ELIZABETH V. JOHNSON (AUNT) 4001 SPRUCE DRIVE BALTIMORE, MARYLAND 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or ö GREEN MOUNT CREMATORY FEBRUARY 10, 2005 BALTO, MARYLAND ZDonation 5 ☐ Other (Specify) 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 21 Signature of Funeral Service Licenses 1412 E. PRESTON STREET BALTIMORE, MARYLAND 21213 23a. Part1. Enter the disease, or complications that caused the darknown Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) monary **Physician** /Medical Due to (or as a consequence of): **Examiner** estri Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner -transit The law requires that the death certificate be executed physician ar Due to (or as a consequence of): P.O. Box 68760 Completed by Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ţ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the aid be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Hinkhown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☑ No 2□No 1 Pes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 10 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 or Attending 5 Pending 1 Matural within 24 hours after death. To the Funeral Diractor: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0030355 FEBRUARY 2, 2005 <0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BON SECOURS 2 K05 124 31. Date filed (Month legistrar's Signature State

Registrar DHMH 17 Rev 1/2001 1 0 2005

			1 - For State Registrar	State of Maryland		artment of H		d Men		ene 005	03973
	Physici		1. Decedent's Name (First, Middle, Last	Bloke					Date of Death	Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of D	eath	245	7 2005 4c. County of Dea	
	ZX		1600 Mt. Rova	1 Ave 309		Balto) .			NIA	
	Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	vin.	Date of Birth Month, Day,	Year)	thplace (State or Foreign
			Usual Residence of Decedent					المدا	une 25	, / 15 / (4	ry land
	Manyla f shov	ō	10a. State 10b. County		1 him						10d. Inside City Limits 1 √Yes 2 □ No
	r 28a-	Director	10e. Street and Number	1.4	inpho	10f. Zip Code			10	g. Citizen of What C	/
	th with	alD	1600 mt. Royal	Are ant 309		212	17			U.S. A	•
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin' n, Mexican, P	? (Specify uerto Rica	Yes or No- n, etc.)	14. Race - Am Black, Whi	
920	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show 'insal Examiner', ust be incitified at	by	1 1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 ∏ No If Yes, Give Year or Dates:	1	I□Yes 2 No	Specify:			Specify: 5	•
21215-0036	72 hours "natural", ulcal Ex.	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed)	16a. Deced	lent's Usual Occupa	ation during most of	working	1	6b. Kind of Business	•
121	be filed within 7 ital Hygiene. id other than "n	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done of OO NOT use retired) -			1 ./.	/.
	illed I Hygie other	e Co	17. Father's Name (First, Middle, Last)			arpente	18. Mother's	Name (Fir	st, Middle, M	on Styuc aiden Sumame)	tion
Maryland	should be and Mental s markad c umatic ev	To Be	John Paul B	lake			Marg	are	+ Fo	rest	
Man	s 1 and 2 should f Health and Mer item 27 is marks othar traumatic		19a. Informant's Name/Relationship (T)	/pe, Print)	19b. Mailin	- 0	and Numberlo	r Rural Ro		City or Town, State,	
-	1 and Healti tem 2		20a. Method of Disposition	20b. Plac	CA I	sition (Name of		Date	11	Md · 2/2 Oc. Location - City or	
mo.	m O - 1-		1 Surial 2 ☐ Cremation 3 ☐ F	removal from State	-11	patony or other place		1/ 3		rownsville	40
Baltimore	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Licens			Name and Address			Tu ner	al Service	o RA
8	89789		Carlon C, h	Jonfan	I	761 MeC	Mak	87.	Bal	b. led. 2	1217
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ne cause on each line.			g, such as car	diac or res	piratory arre	st,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	aAcuteV Due to (or as a consequer	Myoc	andial	I.	for	ction		1 0
	Examiner		Conventially list conditions	b. Coronar			Diss	· a le			6 4
	bd sit	iner	Sequentially list conditions, any factory to the cause. Enter Underlying Cause (Disease or injury	Due to or as a consume	rina offi					79	
_,	akecut al-tran	Examine	that initiated events resulting in death) Last	c Due to (or as a consequer	nce of):						
8760	icate be executed physician and s the burial-transit	dlcai E		d							
9	ing ph	0	IF FEMALE:								
Вох	death certifica attending pl d for use as t	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de	eath 3	Ectopic pregnancy				23d. Date of de Month	livery Day Year
P.O.	that the de ed by the detached	Physiclan/M	1 Yes 2 No 9 Unknown	4∐Pregnant at time of deat 9☐Unknown	uı 5 🗆	Other (specify)					,
	es thal igned b	by P	Part II. Other significant conditions co				en in Part I.		23e. Did toba	cco use contribute to	the cause of death?
ord	w requires been sign should be	eted	14y pertension	, End-shy	e R	enul		_	Yes	2 □ No 3 □ P	obably 4 Unknown
Division of Vital Records,	e las has	Completed	Digeore					-	24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
tal		0	25. Was case referred to medical				26. Place of		perform 1 □ Yes 2		2 No
Ξ	di S	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ EF	VOutpatient	3 DOA Othe	er: 4 🗆 Nursin		. /	ce 6 ☐Other (Spe	cify)
o uc	ling PI		27. Manner of Death Valural 5 ☐ Pending	28a. Date of Injury 28 (Month, Day Year)	Bb. Time of Injury	28c. Injury Work	at ?		Describe how	injury occurred	
risio	Attending it death. actor: After by the funer	flcat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home	e. farm. stre		/es 2□No	28f. L	ocation (Stre	et and Number or Ri	ral Route Number
Ö	s after Bl Dira Bd in b	Certification:	4 Homicide determined	building, etc. (Specify)		y amou			City or Town,	State)	
	Hospi 94 hour Funer Tely fill	edical	(Check only 2) Medical Exemi	sician: To the best of my knowle ner: On the basis of examination	edge, death	occurred at the time estigation, in my op	e, date and pl	ace, and o	lue to the cau	ise(s) and manner as e and place, and due	stated. to the cause(s)
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License				d. Date signed (Mont	
	r>F0) al R	Theren mo		D4	338	36		2.8.05	
			30. Name and address of person who co		За) (Туре, Г	Print)	,		1 1 •		
	C)	10	31. Date filed (Month, Day, Year)	Howard 17	414 E	chaw P	1100	139	1 tous	re, mD	ノコントナ
	Sta Registr		FEB 1 0 20	05 Gove &	A STATE OF	when					

			1 - For State Registrar		arylan		artment of H rtificate of I		and M	R	eg. No2 ()	05	03976
	Physici /Medic		1. Decedent's Name (First, Middle, Last Marion Lucy B	,						2. Date of Deat Month Februar	ny Day 198,20	005 ^{Year}	3. Time of Death 6:00 AM ^M
	Examir	er	4a. Facility Name (If not institution, give Charlestown Ret		Ommuun	itv	4b. City, Town, or Catonsy:		of Death		4c. Count		
	Funeral		Social Security Number 6. Se	x 7. Ag		last birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birth		timo1	place (State or Foreign
	Director		Usual Residence of Decedent	□M 2 🔭 F	96		Months Days	Hours	Min.	Jan. 23,	, 1909	Mass	sachusetts
	e Marylar a-f show	ctor	Maryland Baltimon	re	10c. City	y, Town or Lo Cat	cation consville					1	0d. Inside City Limits 1 Tyes 2 XNo
	h with th	al Director	10e. Street and Number 719 Maiden Choice	Lane #HR	241		10f. Zip Code 21228	3		1	Og. Citizen of United		· ·
920	be filed within 72 hours after death with the Maryland hat Hygiene. od other than "neturel", or flems 23e or 28e-f show event, the Moulical Exarting must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 A If Yes, Give Year or Dates:	,		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin, Mexican	gin? (Spe	ecity Yes or No- Rican, etc.)	Bla	ce - Americ ck, White.	etc.
Maryland 21215-0036	within 72 hi iene. than "netu the Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or:	5+)	(Give life. I	tent's Usual Occupa kind of work done o DO NOT use retired	during most	of workii	ng	Own H	usiness/In	
pu	be filed ital Hygi d other event, I	Be C	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle, A			
ylar	should be and Mental marked o	To	Jeremiah T. Mahor							McPart1			
Mar	ges 1 and 2 should t of Health and Mer If item 27 Is marke or other treumatic		Robert F. Buck				g Address (Street a						
re,	es 1 and 2 of Health a fitem 27 ls r other tree		20a. Method of Disposition		20b. P	lace of Dispo	arylebori sition (Name of natory or other place			everna P	ark, M		
i E	Pages ment of ent: If its ury or o		1 Surial 2 Cremation 3 F				Cemetery)2/11	/05 B	oston,	Mass	achusetts
Baltimore,	permit. Pag Department Importent: I eny injury o		21. Signature of Functor Service Vicens		H13		. Name and Addres		пал	rman Fun	eral S	ervic	e, P.A.
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	lications that cause ne cause on each li	the death	n. Do not ente	er the mode of dying	g, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as		uence of):	C. (13/K)	IEVELE		17-0 10			O DAYS
_		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequ	uence of):							
8760,	death certificate be executed e attending physician and of for use as the burial-transit		that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):							
9	tificate og phys as the	Medic		g									
.O. Box	that the death certifics led by the attending pr detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)					te of delive	ry Day Year
rds, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions co	ntributing to death b			DIO SAS C		Dist		acco use cont	nbute to th	e cause of death?
Vital Record	elaw hasb je2st	Completed								24a. Was ar autopsy perform 1 Yes 2	ed?	prior to cor d <u>ea</u> th?	osy findings available inpletion of cause of
/ita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?						of Death	(Check only one		103	20110
of \	Phys this ral dia	- To	1 Yes 2 No	lospital: 1 ☐ Inpatie 28a. Date of Inju		ER/Outpatien		9∕∟ Nur		ne 5 Reside			')
ion	Attending Phy or death. ector: After thi oy the funeral o	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury	28c. Injury Work M 1 □ Y	? ′es 2 □ N		8d. Describe ho	wanjury occur	180	
Division	el or Attenss after dealing In Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At ho c. (Specily	me, farm, stre	eet, factory, office		2	8f. Location (Str City or Town,	eet and Numb State)	er or Rura	Route Number,
	To the Hospitel or Attenwithin 24 hours after deation to the Funerel Director: completely filled in by the	edicai (29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	sician: To the best ner: On the basis o and manner sta	r examınat	wledge, death ion and/or inv	occurred at the time restigation, in my op	e, date and inion, deat	place, a	nd due to the ca ed at the time, da	use(s) and ma te and place,	inner as sta and due to	ated. the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier	1 1		-	29c. License	number		29	d. Date signe	d (Month, L	Day, Year)
	6		How ~	1.10	6	M, D	De	14	74	8 F	EBRU	arry	8,2005
j	3		30. Name and address of person who co	ompleted cause of o	leath (Item	- (harle	170	w	1 Th	eTI.	6100	8,2005
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	32. Registr 2005	ar's Signat	ture #	Sperter	- '		/ (-			

			1 - For State Registrer		Maryland		artment tificate					giene Reg. No.	005	03975
ı	Physici	an	Decedent's Name (First, Middle	e, Last)							2. Date of Dea Month	Day	Year	
	/Medic	al	Pauline 4a. Facility Name (If not institution	ain street and aum	harl	Cle		r	1	-15	Januar		2005	5:40 PM
	Examin	er	3501 East - We		Der/				Chase				Ounty of De	
	Funeral		5. Social Security Number	6. Sex 7	'. Age (In yrs. la	ast birthday)	If Under	1 Year	_lf Under	24 Hrs.	8. Date of Birt	h	Montgo 9. B	irtholace (State or Foreign
	Director		140-05-6670	1□M 2□F	86	Yrs.	Months	Days	Hours	Min.	oct 27,	1918	N	ew Jersey
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City.	, Town or Lo	cation							10d. Inside City Limits
	Mary 1 sho	ţ	MD Montgo	mery	Che	vy Cha	se							1 ☐ Yes 2 ☑ No
	or 28a	Director	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What C	Country?
	23a c		3501 East West	Hwy.			208	15				USA		
	ar dee	Funeral	11. Marital Status	Armed Fore		S. 13. \	Nas Deced f Yes, spec	ent of Hi rfy Cuba	spanic Ori n, Mexicar	igin? (Spe n, Puerto f	cify Yes or No- Rican, etc.)	. 14	Race - Am Black, Wh	nerican Indian, ite. etc.
36	rs aft	by F	1 ☐ Never Married 2 ☐ Marr. 3 🕅 Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 If Yes, Give Year or Da	Α .		1 ☐ Yes 2	No 🍱	Specify:			s	pecify: W	hite
-0	72 hours after deeth with the Maryland Inatural, or Itams 23a or 28a-1 show alsed Evarth at malat be multified at		15. Decedent	's Education		16a. Deced	ient's Usua	Occupa	ation				of Busines	
218	within 7 ene. than "n	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-	4or 5+)	life. I	kind of wor DO NOT us	e retired	luring mos)	t of workir	ig			·
21	e filed w al Hygien other th		12	1 - 1		Hom	emake	r					Home	
Maryjand 21215-0036	s 1 and 2 should be filed within 72 hours after deeth with the Marylan if Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itams 23a or 28a-1 show other traumatic evant, the Medical Evarultat man traus) Be	17. Father's Name (First, Middle, Stephan Deneka	Lasi)							(First, Middle, lra Pol		,	
aryi	2 should be f and Mental H is marked of raumatic eva	2	19a. Informant's Name/Relationsl	hip (Type, Print)		19b. Mailin	ng Address	(Street a			Route Numbe			Zip Code)
	and 2 alth a 27 is		Joan Cleary Cha	rles							vy Cha			
ore	es 1 and 2 of Health of itam 27 i		20a. Method of Disposition 1 Burial 2 Cremation	3 Demousifron S		ace of Dispo	sition (Nam	e of her place	9)	D	ate	20c. Loca	tion - City o	r Town, State
Ë	Pag ment tant: l		`4 □Donation 5 □ Other (S)	pecify)		of th	e Hol	y Ro	ood	2-5-0)5	West	bury,	New York
Baltimore,	permit. Pages Department of H Important: If its any injury or of		21. Signature / Funeral Service	Licensee	100)() 22	Mack							
	20240		23a. Part 1. Enter the disease, or	complications that ca	used the death	Do not ent							Centr	e, New York Approximate
	Fnysician	(Immediate Cause (Final	only one cause on ea	ch line. ntal Lo				g, 30011 a3	cardiac of	respiratory an	1631,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a	ras a consequ		men cr	a 			_			Years
П	Examiner		Sequentially list conditions	b. ———										
7	sit ad	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Chuse [Disease or injury]		r as a conseque	ence of):								T
V	xecute and Il-tran	Examine	that initiated events resulting in death) Last	c	r as a conseque	ence of):								
8760,	cate be executed physician and the burial-transit	dical E												
9	tificat ng phy as the	Ø -		u										
Вох	death certific e attending p id for use as i	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outc 1 ☐ Live bir	ome of pregnan th 2 Fetal		Ectopic pre	egnancy				23	d. Date of de	
G	ne dea the at hed fo	/sicl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregna 9☐ Unknov	nt at time of dea		Other (spe						Month	Day Year
<u>α</u>	that the de led by the a detached t		Part II. Other significant condition	ns contributing to dea	ath but not resul	Iting in the ur	nderlying ca	use give	on in Part I.		23e. Did to	bacco use	contribute	to the cause of death?
ds,	es pe	d by	Mitral Valve			3	, ,	3						Probably 4 Unknown
of Vital Record	> 11 ()	ompleted									24a. Was a	an	24b. Were a	utopsy findings available
Re	9 4 9	mo									autop perfor 1 Yes		prior to death? 1 ☐ Ye	completion of cause of
ita	ryslcien: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?						26. Place	of Death	Check on or			3 2 110
of V	Physicien: this certific ral director,	은	1 ☐ Yes 2 🛣 No		patient 2 E			-	4 🗀 140	ırsing Hon	ne 5⊠Resid	ence 6[Other (Sp.	ecify)
ou c		lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pendin		Day Year)	28b. Time of Injury		3c. Injury Work			8d. Describe h	ow injury	occurred	
Division	l or Attsnding after death. Diractor: After I in by the fune	ficat	2 Accident investig	not be 280 Place	of Injury - At hor	ne, farm, str	M eet. factory		/es 2□		8f. Location /S	itreet and i	Vumber or F	Rural Route Number.
<u>S</u>	o the	Certification:	4 Homicide determ	buildin	g, etc. (Specify))	001, 1001017	011100			City or Tow		vamour or r	istar route rumber,
	To the Hospital or Attsm within 24 hours after deat To tha Funaral Diractor: completely filled in by the		29a. Certifier 1 Certifyin	g Physicien: To the t	est of my know	rledge, death	occurred a	at the tim	e, date an	d place, a	nd due to the o	ause(s) ar	nd manner a	s stated.
	the H hin 24 tha F nplete	Medical		Exeminer: On the bas and manne	er stated.	on and/or in				tn occurre				
	or To CO	-	29b. Signature and title of conflien	Kon	. //			D098	number		2			th, Day, Year)
			30 Name and address of person	who completed source	of death (line	232) /Trees		D090	,,,,,			renI	uary .	3, 2005
	10		Barry N. Rose	nbaum, MD	3720	Farrag	ut Av	enue	Ken	singt	on, MD	2089	5	
	Sta		31. Date filed (Month, Day, Year)	107	gistrar's Signatu	A.			-					
	Registr	ar	FEB 1 G 200	5 Steems	15	Gosele	1							

			1 - For State Registrar	State of Marylar			nt of H te of L		ind M		iene,	2005	03	976
	Dhamis		1. Decedent's Name (First, Middle, La	st)						2. Date of Deat Month	h Day	Vone	3. Time of	Death
	Physici /Medi		Maude Russel	1 Crawford	i					Februar	y 5	, 2005	1:20	P M
	Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City	Town, or	Location o	f Death			County of Death		
			Bradford Oaks Nu				nton				P	rince Ge	eorge's	3
	Funeral		5. Social Security Number 6. S	X _		If Unde Months	r 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month Day April 3	Year)	9. Birth	place (State o	or Foreign
	Director		239-30-7354 Usual Residence of Decedent	□ M 2LΩF 86	Yrs.					April 3	, 19	918 Geor	rgia	
	and w		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation							10d. Inside Ci	ity Limits
	Mary 1 ehc	ō	Maryland Prince G	leorge's For	t Wash	ningt	On						1X Yes	-
	28a-	ect	10e. Street and Number	scorge s 101	. C Wasi		p Code			10	On Citiz	en of What Cou	ntn/2	
	With Ba or	0	514 Potomac Valle	v Drive			744				U.S.			
	ms 2	Funeral Director	11. Marital Status	<u> </u>	.S. 13.	Was Dece	edent of His	spanic Orig	gin? (Spe	city Yes or No-	_	4. Race - Amen	can Indian,	
9	or Ite	Ē	1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 🛣 No					, Puerto F	Rican, etc.)		Black, White,	etc.	
93	ral', c	b	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 🗌 Yes	2∐J No	Specify:				Specify: Bla	ack	
5-0	72 hours after death with the Maryland natural', or items 23a or 28a-1 ehow Jisal Examinar must be notified at	Completed	15. Decedent's E (Specify only highest gra	ducation	16a, Dece	dent's Usu	ai Occupa	ition	of working	10	6b. Kin	d of Business/Ir	dustry	
2	ithin	npi	Elementary/Secondary (0-12)	College (1-4or 5+)				u <i>ring</i> most						
2	2 should be filed within and Mental Hygiene. Is marked other than "aumatic event, the Me		12		Вє	eauti	cian					smotolog	ЗУ	
<u>n</u>	be fill	Be	17. Father's Name (First, Middle, Last,)						(First, Middle, A	faiden S	Витате)		
<u>\</u>	should ind Men s marke umatic	ို	Arthur Lee							illips				
Maryland 21215-0036	12 sh nanc risin		19a. Informant's Name/Relationship (Charlayna Gilmer			-				Route Number,				- / /
	ss 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. It health and Mental Hygiene item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition		DI4 .			аттеу		, Fort V				/44
ō	a o		1 ☑Bunat 2 ☐ Cremation 3 ☐	Removal from State	emetery, crei	matory or	other place					ation - City or T		
ţ	t. Pa tmen tant:		`4 □Donation 5 □Other (Specif		dmont							eensbor	o, NC	
Baltimore,	permit. Page Department Important: It any injury o		21. Signature of Funeral Service Licer	ettmeen	2	Perry 909 E	nd Addres J. I . Mai	s of Facility Srown cket	Fune	eral Hom Greenst	e oro	, NC 27	420	
8760,	Cate be executed hysician and hysician and the burial-transit the buri	cal Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect to or as a consect to do or as a consec	uence of):	Λ.	Sem						Approximate Interval Bets Onset and D	ween
P.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and toge 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 ☐ Yes 2 전 No 9 ☐ Unknown	23c. If yes, outcome of pregni 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	Ideath 3	□Ectopic p □ Other (s					25	3d. Date of delive	,	/ear
	ires that signed t d be det	by	Part II. Other significant conditions of	contributing to death but not res	ulting in the u	nderlying	cause give	n in Part I.		23e. Did tob		e contribute to t	he cause of do	
Ö	w requir been si should I	ete								-				
Vital Records,	The lavate has	Completed								24a. Was an autopsy perform	,	24b. Were auto prior to co death? 1 \(\subseteq \text{Yes} \)	mpletion of ca	available ause of
ita	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place	of Death	(Check only one				
of V	S 5	To	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 🗆 D	OA Othe	r: 4 🛚 Nur	sing Horr	ne 5 Reside	nce 6	Other (Specif	(y)	
0	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f	28c. Injury Work	at ?	2	8d. Describe ho	w injury	occurred		
Ö	tending death. tor: A the fu	atic	2 Accident investigation			M		es 2 N	10					
Division	tal or Attendests after death	Certification;	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - At h building, etc. (Specia	ome, farm, str y)	reet, factor	y, office		2	8f. Location (Str City or Town	eet and State)	Number or Rura	il Route Numi	oer,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1	nysicien: To the best of my knowniner: On the basis of examination and manner stated.	wledge, deat tion and/or in	h occurred vestigation	at the time	e, date and inion, deat	d place, at h occurre	nd due to the ca d at the time, da	use(s) a te and p	nd manner as s place, and due to	tated. the cause(s)	
	To To t	Σ	29b. Signature and title officertifier	^		29	c. License			29	d. Date	signed (Month,	Dey, Year)	
			Mille 11	anus			D32	206			Fel	> 44477	215	•
	Q		30. Name and address of person who	completed cause of death (iter	n 23a) (Type,	Print) 1	1701	Livin	igsto	n Road	#101	, , ,	-0-3	
	ď		William T. Tolerna	/ un					-	, Maryl				
	Sta Registi		31. Date filed (Month Day, Year) 20	3 Registrar's Signa	yure do	and it	0							

_			1 - For State Registrar	State of M	laryland / Depa		Health ar			05	03977
	Pĥysic	ian	1. Decedent's Name (First, Middle	, Last)				2. Date of De	ath Day	Year	3. Time of Death
	/Medi		Соу	н.	Condon	IV		FEBRUA	RY 7, 20	005	6:11A. M
	Exami	ner	4a. Facility Name (If not institution, NORTH POINT ROA	D & BAUERS	FARM ROAD	EDGEM			4c. County BALTI	of Death MORE	
	Funeral Director		5. Social Security Number 216–80–4688 Usual Residence of Decedent	6. Sex 7. A	ge (In yrs. last birthday) 30 Yrs.	If Under 1 Yea Months Day		Hrs. 8. Date of Bird Min. (Month, Da December	th Year) 8,1974	9. Birthp Cour MD.	place (State or Foreign ntry)
	yland		10a. State 10b. County		10c. City, Town or Lo	cation				1	0d. Inside City Limits
	n the Marylan r 28a-f show	ctor	MD Balti	more	Edgemere	9					1 ☐ Yes 2 No
	death with the Maryland ms 23a or 28a-f show	Dire	10e. Street and Number			10f. Zip Code	•		10g. Citizen of V	Vhat Cour	ntry?
	s 23a	ra	2309 Lodge Farm			212			USA		
9	ges 1 and 2 should be filed within 72 hours after death with to f Health and Mental Hygiene. If Item 27 Is marked other than "natural; or items 23a of or other traumatic event, I'm Medical Exartitus must be	Funeral Director	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Armed Forces at 1 Yes 2X	? No			n? (Specify Yes or No- Puerto Rican, etc.)	- 14. Rac Blac	e - Americ k, White,	ean Indian, etc.
003	72 hours after "natural", or Ite	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 □XN	lo Specify:		Specify	Wh:	ite
21215-0036	in 72 in 72 in at	Completed	15. Decedent (Specify only highest	grade completed)	(Give	lent's Usual Occ kind of work dor DO NOT use reti	ne durina most o	f working	16b, Kind of Bu	siness/Ind	dustry
212	d within giene. or than "	mo	Elementary/Secondary (0-12) 12 years	College (1-4or	5+)		ine Work	er	General	Moto	ars
	at Hyg d othe	BeC	17. Father's Name (First, Middle, L	ast)	, , , , , , ,	<u> </u>		Name (First, Middle,			JI 5
yla	2 should be filed withir and Mental Hygiene Is marked other than aumatic event, Inv M	2	Coy H. Condon					D. Plummer			
Maryland	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationsh Peggy Condon	ip <i>(Type, Print)</i> Mothe:				or Rural Route Numbe d, Edgemere			Code)
	s 1 an f Heal fem 2 other		20a. Method of Disposition	Poche	20b. Place of Dispo			Date Date	20c. Location -		wn. State
Ë	Pages nent of nt: If I		1 XBurial 2 □ Cremation `4 □ Donation 5 □ Other (Sp		Oak Lawn		1 - 0	bruary			
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trat once.		21. Signature of Funeral Service L	icensee				0, 2005	Dundalk	, Ma.	21222
	2012 9 9		Introny	Conne	Cly 7	110 Sol1	lers Poi	Home Of I	oundalk,	MD. 2	21222
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	complications that cause only one cause on each I	d the path. Do not entrine.	er the mode of dy	ying, such as ca	rdiac or respiratory an	rest,		Approximate Interval Between Onset and Death
	Pnysician /Medical-		Immediate Cause (Final disease or condition resulting in death)	a Mult	aple in	Luric	25				Chock and Death
	Examiner			Due to (or as	a consequence or):	3					
/	pe iis	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):						
	sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of);						
8760,	ate be executed physician and the burial-transit	calE		4							
9	rtificate ng phys as the	Medi	IS SELLIN S	U							
Вох	death certifica attending ph d for use as tl	lan/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnan	су			of delive	•
o.	The law requires that the death certific Ite has been signed by the attending p tage 2 should be detached for use as:	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant a 9 Unknown	t time of death 5□	Other (specify)			Mon		Day Year
Ω.	signed b	by Pr	Part II. Other significant condition	s contributing to death b	out not resulting in the un	derlying cause g	oven in Part I.	23e. Did to	bacco use contri	bute to the	e cause of death?
Vital Records,	w require been sig should b							1 U Y	es 2 No	3 🗌 Proba	ably 4 Unknown
Sec.	has be	Completed						24a. Was a autops	sy pi	ior to com	sy findings available
a		e Co	OF Man anno referred to souther					1 Yes	med? de 2□No 1	Yes 2	2□ No
5	Phyaiclan: this certific ral director,	To Be	25. Was case referred to medical examiner? [X] Yes 2 \[\] No	Hospital:	ent 2 ER/Outpatient	3[] DOA O	ther	Death (Check only on ng Home 5 Reside			SCENE
	ding Phy h. After thi funeral o		27. Manner of Death	28a. Date of Inju (Month, Da	ry 28b. Time of	28c. Inju		8d. Describe ho			- vahida
Division	or Attending ifter death. Director: After in by the fune	Certification;	1 □Natural 5 □ Pending 2 ★ Accident investiga 3 □ Suicide 6 □ Could no	tion $\geqslant -7$.	-05 061		Yes 2 No	ar ver	ed in C	olli	Sim
Ν	f or Attend after death Director: , I in by the f	ertif.	4 Homicide determin		ury - At home, farm, stre c. (Specify)	et, factory, office	9	28f. Location (St City or Town	tree and Number, State)	r or Rural	Route Number,
	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying	Physician: To the best	of my knowledge death	occurred at the	time, date and of	FORM RO	DO3 LS	ene	Re, NO
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	(Check only 2 X Medical E: one)	kaminer: On the basis o and manner sta	i examination and/or inv	estigation, in my	opinion, death o	occurred at the time, d	ate and place, a	nd due to	the cause(s)
	To the h within 2 To the F complete	Σ	29b algnature and title of certifier	000		29c. Licen	se number	2	9d. Date signed	(Month, D	Pay, Year)
			fahle	_ rolle	C ms	OC	ME	F	EBRUARY	7,20	005
	10		39. Name and address of person w	ho completed cause of d	eath (Item 23a) (Type, F		G:				1 01 000
	Sta	te	31. Date filed (Month, Day, Year)	32. Figistr	ar's Signature	III Po	enn Stre	eet Baltimo	ore, Mar	ylan	d 21201
	Registr	ar	FEB 1 0	2005 Sere	w it so	COL LAND					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 4 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year **Physician** 4:55 PM hittu Konald 13000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore ospita N/A Center Harbor If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1X M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 53 Yrs Director UNK. Virginia NOV_30. 1951 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 No Directo Maryland Anne Arundel Odenton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 538 Old Waugh Chapel Road 21113 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Landscaper Landscaping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0 Harold Wilson Chittum Josephine Elizabeth Blankenship 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Gaskin/Sister 538 Old Wau h Charel Road Odenton, MD 21113 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metro Crematory, Inc. 2/9/05

22 Name and Address of Facility
Cremation Society of MD, Inc. ¹ 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee Sono Edward A. Gregorchik 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Die to (or as a consequency of): Three weeks /Medical Examiner So uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last cance Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician by Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) Yes detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pg 2 No 3 Probably 4 □Unknown 1 🗌 Yes s need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2 3 No Hospital or Attending Physician: 26. Place of Death (Check only one.

certificate has funeral director, After this death.

hours after death uneral Director: filled in by within 24 hours a To the Funeral C completely

Be Completed 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient Certification: To 1 Yes 2 EM 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 2 No 1 🗌 Yes investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide Techtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 2441614-837 February 7, 2005 Harover Street, Baltimore City, Mayle 3001

31. Date filed (Month, Day, Year) State

32. Registrar's ignature 2003

Registrar

		1	1 - State of Marylan	•	artment of H tificate of L			giene Reg. No. 2005	03979
	Physicia		1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	ath Day Year	3. Time of Death
	/Medic	al .	Edward Alfred Cook		4b. City, Town, or	Landing of D	Feb.	7 2005 4c. County of Dea	
	Examin	er	4a. Facility Name (If not institution, give street and number) 6945 Eden Mill Road	İ	Woodh		g atn	Carrol	
	Funeral			. last birthday)	If Under 1 Year	If Under 24 I		h 9. Bir	thplace (State or Foreign
	Director		214-28-1048 ^{1⊠M 2□F} 76	Yrs.	Months Days	Hours N	Feb. 1		ryland
	pup *		Usual Residence of Decedent 10a. State 10b. County 10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Maryli f sho	ō		oodbine					1 ☐ Yes 2 🖾 No
	r 28a-	Directo	10e. Street and Number	DOUBLIFE	10f. Zip Code			10g. Citizen of What Co	ountry?
	th with		6945 Eden Mill Road		2179	7		United Sta	ites
	ams arra	Funerai	11. Marital Status 12. Was Decedent Ever in Armed Forces?		Was Decedent of Hi f Yes, specify Cuba	spanic Origin' n, Mexican, P	(Specify Yes or No- uerto Rican, etc.)	- 14. Race - Ame Black, Whit	
36	s afte	by Fu	1 □ Never Married 2 □ XMarried 1 □ XYes 2 □ No 19 If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates: 19		1 ☐ Yes 2 ☑ No	Specify:		Specify: B	Black
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23s or 28s-f show ther the Medical Exard withink to notified at		15. Decedent's Education	16a. Deced	dent's Usual Occupa	ation		16b. Kind of Business	/Industry
215	hin 73 8. 8n "na Medi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life.	kind of work done o DO NOT use retired	dunng most of ()	working		
21	filed wit Hygiene other the	Con	12th	Cabin	et Maker			Self-emp	loyed
Ē	m - 0 %	Be	17. Father's Name (First, Middle, Last)				Name (First, Middle,	Maiden Sumame)	
Maryland 21	should be filed within 72 hours after death with the Marylan and Mental Hygiene. Ind Mental Hygiene. Is marked other then "natural; or Itams 23a or 28a-f show marked other then "natural; or want, the Medical Exactimetre event, the Medical Exactimetre and the profithed at	ဥ	Alfred Augusta Garfield C 19a. Informant's Name/Relationship (Type, Print)		ng Address (Street a		.1a Jason r Rural Route Numbe	er, City or Town, State,	Zip Code)
<u>s</u>	and 2 she ealth and m 27 is m har traum		Mrs. Martha Ann Cook wife		Eden Mil			e. MD 21797	
ē,	of Hea of Hea fitam rotha		20a. Method of Disposition 20b.	Place of Dispo	sition (Name of natory or other place		Date	20c. Location - City or	
altimore,	Pages nent of I ant: If its ary or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Ponation 5 ☐ Other (Specify)				. 11, 200	5 Taylors	ville, MD
Balt	permit, Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es once.		21. Sturature — Funeral Service Ligensee MMMM MMMM MMMM MMMM MMMM MMMM MMMM	Bu 12	12 W. Old	en Fun l Liber	ty Road I	& Cremator Winfield, M	y, PA D 21784
			23a Part 1. Enter the disease, or complications that caused the decision of the shock of heart failure. List only one cause on each line.	ith. Do not ent	er the mode of dying	g, such as car	diac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition esulting in death) a Due to (or as a conse	equence of):	11100:	12.7107			19ear
	Examiner		Sequentially list conditions.	- 8					
	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Closeas or finitely.	quence of):					
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	equence of):					
8760,	sician sician burit	dicai E	d						
မ	tificate ig phy as the	ledic						1 5	
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bace 2 hould be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
Δ.	res that the de signed by the a l be detached f	by Ph	Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use contribute t	o the cause of death?
rds	requires						_ 1/2`	Yes 2□No 3□P	robably 4 Unknown
Vital Records,	a law re	Completed					24a. Was		utopsy findings available completion of cause of
E							1 ☐ Yes	2 No 1 Yes	3 2 No
Z.	siciar certif rector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth	oc	Death (Check only o	<i>yne)</i> dence 6 ⊡Other (<i>Spe</i>	acity)
of	Attending Physician: The r death. actor: After this certificate his contilicate his the funeral director, page	h- +	27. Manner of Death 28a. Date of Injury	28b. Time o				how injury occurred	cny)
ion	nding ath. r: Afte e fun	atio	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury		Yes 2 □ No			
Division	- 9	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined building, etc.)	home, farm, str cify)	reet, factory, office		28f. Location (: City or Tox	Street and Number or R wn, State)	ural Route Number,
	To the Hospital or within 24 hours af To the Funeral D completely filled in	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the tin evestigation, in my o	ne, date and p pinion, death	place, and due to the occurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To tha Hos within 24 h	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed (Mon	th, Day, Year)
			1 Kaus		024	158		2/10/65	
	2+1		30. Name Ind address of person who completed cause of death (It	em 23 <i>a</i>) (Туре,	Print)			1	
	St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Sig						
	Regist	rar	FEB 1 0 2005	. K	and I				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** 2005 05:10 AM 05 02 Goldie Lee Cooper /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 212 F Months Days Hours Min. Director West Virginia 236-30-5446 08/14/1923 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits or Itams 23a or 28a-f show urrer roust be notified at 1 ☐ Yes 2X No Director Harford Forest Hill 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2018 Phillips Mill Road 21050 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ☐Yes 2 X No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: by The Mudical Exar-If Yes, Give Year or Dates: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Lab Technician Edgewood Arsenal 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fill and Mental H is marked off Be ဂ္ Jessie Claude Boyd Mary Lucy Whitlock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Itam 27 i 2154 Howell Road - Malvern, Pennsylvania 19355 John E. Cooper (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) injury or Bel Air Memorial Gdns.02/12/2005 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. assaka 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ischemic Pnysician bowl /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cheane or high) that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of); Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 9. Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed certificate Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P Division of 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a
To the Funeral I
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) D34652 30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) Bil Air Manyland 21014 Avinue 2 North

State Registrar 31. Date filed (Month, Day, Year)

0 2005

32. Registrar's Signature

		ľ	State of Maryland / Del	partment of ertificate of			iene g. No.	005	03981
			Decedent's Name (First, Middle, Last)			2. Date of Deat	h		3. Time of Death
	Physici /Medic		Marjorie Hottes Casey		1	Feb.	Day 7	Year 2005	8:58 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town,	, or Location of Death		4c. Cour	ity of Death	
			Gilchrist Center	Tows		0.0	Bal	timore	
	Funeral Director		5. Social Security Number 219-10-3354 6. Sex 1 M 2 F 7. Age (In yrs. last birthde	Months Days		8. Date of Birth (Month, Day,		9. Birthi	place (State or Foreign ntry)
			Usual Residence of Decedent			Oct. 4	1924	MD	,
	larylan show	_	10a. State 10b. County 10c. City, Town or					1	10d. Inside City Limits
	ha Ma 18a-f	octo	MD Baltimore Towso		_				1 ☐ Yes 2X No
	with the sor 2	吉	10e. Street and Number	10f. Zip Code		10	Og. Citizen o		ntry?
	ter death with tha Maryla Hems 23a or 28a-f shov	Funeral Director	601 Round Oak Rd. 11. Marital Status 12. Was Decedent Ever in U.S. 13		1204 f Hispanic Origin? (Spe	cify Yes or No-	US	ace - Americ	can Indian
9	after or Iter		1 Never Married 2 Married Armed Forces? 1 Yes 2 No If Yes, Give		f Hispanic Origin? (Speuban, Mexican, Puerto F	Rican, etc.)	В	lack, White,	etc.
003	urel', c	d by	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 No	lo Specify:		Spec	cify: W	hite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or tems 23a or 28a-f show int, the Medical Ezerr net med be notified at	Completed by	15. Decedent's Education 16a. Decedent's education (Specify only highest grade completed) (Gi	cedent's Usual Occu ve kind of work done	upation ne during most of working red)	g	16b. Kind of	Business/In	dustry
12	withir ene. than	d L	Elementary/Secondary (0-12) College (1-4or 5+)	omemaker			O	n Hom	
	be filed htal Hygi ad other event, I	Be C	17. Father's Name (First, Middle, Last)	Jillemaker	18. Mother's Name	(First, Middle, A			ie
<u>/a</u>	g to 20 9	To B	James Vernon Hottes		Caroly	yn Zink			
Maryland	s 1 and 2 should be f f Health and Mental h Item 27 Is markad or other traumatic eve		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Stree	et and Number or Rura	Route Number,	City or Tow	n, State, Zip	Code)
2 0	1 and 2 Health iem 27	18			Oak Rd.,	The state of the s			
200	0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	position (Name of rematory or other pl	D.	ate	20c. Location	n - City or To	own, State
当主	permit. Pag Depurtment Impurtant: I any njury o		* 4 □ Donation 5 □ Other (Specify) Jessops 21. Signature of Funeral Sequice ≠Consess	Church 22. Name and Addi	Cemetery 2	2/9/05	Spark	ks, Mi	D
Ba	Departition of the policy of t		1 SI WOUL	Lemmon F	Funeral Ho	me of D	ulane	y Vall	ey, Inc.
	-		23a. Part1. Ent. the dease, or compound in that caused the death. Do not e	onter the mode of dy	denia Rd., ying, such as cardiac or	Timeni respiratory arre	um, A	1D 210	Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	(. / A No.	C6115 -				Onset and Death
00	/Medical		resulting in death) a. Due to (or as a consequence of):	2070	cancer				worths
30	Examiner		Sequentially list conditions.						
~	sit s	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
7	cata be axecuted obysician and the burial-transit	Examiner	resulting in death) Last C						
1A71 8760	a be a sician buria	dicai E							
177		ledic							
S ×	Tha law requires that the death certific Ite has been signed by the attending p vage 2 should be detached for use as:	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	B Ectopic pregnan	ıcv		1	Date of delive	,
0.	e dea the at	sici		Other (specify)			, N	Month	Day Year
P. 0.	res that the de signed by the a l be detached f	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underhing cause c	gwen in Part I	23e Did tob	2000 USB 00	intribute to th	ne cause of death?
ds,	uires l signe			andonying daddo g	givon in r airi.	1 X Ye			bably 4 Unknown
Sor	w requir been si should	Completed				24a. Was ar	24h		
R.	Tha lav	dwc				autopsy	ted?	death?	psy findings available mpletion of cause of
)A		0	25. Was case referred to medical		26. Place of Death		DD/No	1 🗆 Yes	2 LI No
7 5	di S	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	ent 3 DOA	Other: 4 Nursing Hom			ther (Specify	w hospice
C			27. Manner of Déath 1/SNatural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Inju	jury at 2 fork?	8d. Describe ho	w injury occi	urred	
Sio	r Attending er death. rector: After by the fune	cati	2 Accident investigation		□Yes 2□No				
35	o afte	ertification;	4 Homicide determined 28e. Place of Injury · At home, farm, building, etc. (Specify)	street, factory, office	е 2	8f. Location (Str City or Town		nber or Rura	d Route Number,
Ť.	urs urs ille	O	29a. Certifier Certifying Physician: To the best of my knowledge, de	ath occurred at the	time date and place a	nd due to the ca	use/s) and r	manner as el	tated
	To the Hosl within 24 ho To the Fund completely f	edical	(Check only 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my	opinion, death occurre	d at the time, da	te and place	e, and due to	the cause(s)
	To the within 2 To the complet	Z	29b. Signature and title of certifier	29c. Licer	nse number	29	d. Date sign	ned (Month,	Day, Year)
	1		Marsus	D	58303	F	E5~	254	7 2005
	Q		30. Name and address of person who completed cause of death (Item 23a) (Typ	e. Print)	CL AIL		0 71	70 (2)	
	* CA-	to	AAON J. UAAVS VV GOO N 31. Date filed (Month, Day, Year) 32. Registrag's Signature	Nat Cos	D1 12011	mune VVI	11 4	my	
	Sta Registi		FER 1 A 2005 L	A. A.					
			TEBLU 2000 Alexan A	- COSME					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

03982 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 8:47 PM February 7,2005 Ljubisav K. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Baltimore Parkville Ouail Hill Assisted Living
cial Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year)
Oct.1,1907 If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Months Hours Days 1**X** M 2 □ F 97 Vre Director 311-32-0867 Yugoslavia permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. important: if item 27 is marked other then "natural", or item a 29 or 28a-f show eny injury or other traumatic event, the Medical Evanding Invist be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XNo Maryland 4 8 1 Directo Baltimore Parkville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9900 Walther Boulevard Funerai 21234 United States
14. Race - American Indian 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ★ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: 2 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ciric unk. unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Thomas M. Zizic , Son 7208 Bellona Avenue Baltimore, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Dulaney Valley Memorial Gardens 2/11/05 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brian T. Chisholm F.S., P.A. 21. Signature of Funer I Service Licensee 200 E. Padonia Road, Timonium, MD 21093 -M01113 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /iviedicai Examiner Due to (or as a consequence of): Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 1 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 24 No 1 ☐ Yes 1 ☐ Yes 2 ☑ No i or Attanding Physician: after death.
Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitai within 24 hours a To the Funerai Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 22472 141 30. Name and eddress of person who completed cause of death, (Item 23a) (Type, Print) Blice 5601 Loch 31. Date filed (Month, Day, Year) 32. Regierar's Signature FEB 1 0 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03983 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month Sue inda February 19:40 OT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOPKINS HOSPITAL N/A JOHNS 8. Date of Birth (Month, Day, Year) NOV.15,1946 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours 1 M 2 F Yrs. Director 217-46-2187 58 MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10d. Inside City Limits if itam 27 is marked othar than "natural", or items 23a or 28a-1 show or othar traumatic evant, the Madical Examinar must be nothed at 1 Yes 2 No Director FAIRFAX V٨ RESTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2003 CUTWATER COURT 20191 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after to not of Health and Mental Hygiene. Int: if item 27 is marked othar than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No WHITE Specify: Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 TEACHER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WOLFE COHEN AI FRED ROSE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11012 VALLEY HEIGHTS DRIVE - OWINGS MILLS, MD 21117 RONA WEINER / SISTER 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or one. BETH EL MEMORIAL PARK 02/09/2005 RANDALLSTOWN, MD 5 ☐ Other (Specify) 4 Donation of Fineral Salice Licens 21. Signat 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Pany. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 48 nrs Priysician Gastrointestina leeding /Medical Due to (or as a consequence of): **Examiner** Neuro endocrine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-transit Due to (or as a consequence of): the attending physician ned for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by rector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 X NO 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funaral Diractor: After thi
completely filled in by the funeral 28a. ate of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide fo the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mi bruary

187

State Registrar

DHMH 17 Rev 1/2001

Baltimore

21287

address of person who completed cause of death (Item 23a) (Type, Print)

North

URPHU

2005

31. Date filed (Mante, Day, T

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® 03984 1- State Registrar AMEND ITEM #19a PER INF C846 estificates of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month MARTHA D. DERDA 09.00 AM FEB. 8, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death UPPER CHESAPEAKE MEDICAL CNTR. BELAIR HARFORD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1□M 2XF Director 215-05-9024 Yrs. 89 3/10/15 NEW JERSEY Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Director 1 Yes 2 □ No N/A MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6811 BOSTON AVE. 21222 USA Completed by Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 8 HOMEMAKER HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be f and Mental I JAMES PARIS MARY JARCYNSKI 19a. Informant's Name/Relationship (Type, Print)
MELVIN
MR. MRLVIN DERDA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Importent: If Item 27 is
any injury or other treu 3809 GRENTON AVE. BALTIMORE, MD. 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🛱 Burial 2 □ Cremation 3 □ Removal from State HOLY ROSARY 2/12/05 DUNDALK , MD. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee KACZOROWSKI FOR TUNERAL HOME P.A. Lostnes u DUNDALK AVE. BALTIMORE, MD. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lischemic disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): 68760 The law requires that the death certificate be Physician/Medical P.O. Box IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 □ No 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Nnpatient 2 ER/Outpatient 3 DOA Division of 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred Hospitel or Attending 1 Natural s after decreix after Director: After the f 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined fo the ... within 24 hours a... To the Funerel Dirr

Records,

100 AM

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

20056607

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TOSEPH ANGIELO Scule # 205, 6

S ATWOOD RU. BELAIR MD

2005 21014

Registrar

Medical

31. Date filed (Month, Day, Year)

29a. Certifier

32. Registrar's Signature

ding physician and bearing in the way and bearing the way and bearing the way and bearing the way and bearing the way and bearing the way and bearing the way and bearing the way and bear then "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Modical Examiner any injury or other traumatic event, the Modical Examiner any injury or other traumatic event, the Modical Examiner any injury or other traumatic event, the Modical Examiner and the following the complete day Funeral Director	Social Security Number 212-32-5499 Sual Residence of Decedent Oa. State 10b. County M. d Oe. Street and Number	7. Age (In yrs. 68 7 10c. City 10c. City 10c. City 11c.	Ist birthday) If U Acres Tyrs. If U Mon Tyrs. If U Mon Tyrs. It I Mon Tyrs. It I Mon Tyrs. It I Mon Tyrs. It I Mon Tyrs. It I Mon Tyrs. It I Mon Tyrs. It I Mon If Yes, I I Mon I I I I Mon I I Mon I I Mon I I Mon I I Mon I I Mon I I Mon I I Mon I I Mon I I Mon I I Mon I I Mon I I Mon I Mon	Inder 1 Year If Under 24 If this Days Hours IN Hours IN Hours IN Hours IN Hours IN Hours IN Hours IN Hours IN Hours IN Hours IN Hours IN Hours IN Hours IN Hours IN Hours IN Hours IN Hours IN Hours IN Hours IN HOURS IN H	As of Hrs. 8. Date of Billin. 8. Date of Billin. 3.— 6. Month, D. 3.— 6. Month, D. 3.— 6. Month, D. 3.— 6. Month, D. 3.— 6. Month, D. 3.— 6. Month of the second of the se	10g. Citizen of What (US 1-36 114. Race - An Black, Wh Specify: B 16b. Kind of Busines TRANSPO 9. Maiden Sumame) Der, City or Town, State 20c. Location - City or Batho. Company Compa	Sirthplace (State or Fo Country) 10d. Inside City Li 10d. Inside City
physician and points are strong by a stron	Social Security Number 2/2-32-57499 Sual Residence of Decedent Oa. State 10b. County Ma Obe. Street and Number 1. Marital Status 1. Marital Status 1. Mever Married 3. Widowed 4. Divorced (Specify only highest grad Elementary/Secondary (0-12) 7. Father's Name (First, Middle, Last) 9a. Informant's Name/Relationship (7) Obe. Method of Disposition 1. Burnal 2. Cremation 1. Signature funeral Service Lice 1. Signature f	7. Age (In yrs. 68 7 10c. City 12. Was Decedent Ever in U. Armed Forces? 1	Ist birthday) If U Acres Tyrs. If U Mon Tyrs. If U Mon Tyrs. It I Mon Tyrs. It I Mon Tyrs. It I Mon Tyrs. It I Mon Tyrs. It I Mon Tyrs. It I Mon Tyrs. It I Mon If Yes, I I Mon I I I I Mon I I Mon I I Mon I I Mon I I Mon I I Mon I I Mon I I Mon I I Mon I I Mon I I Mon I I Mon I I Mon I Mon	Inder 1 Year If Under 24 If this Days Hours Management of Hispanic Origin? Specify Cuban, Mexican, Property Cuban, Mexic	As of Hrs. 8. Date of Billin. 8. Date of Billin. 3.— 6. Month, D. 3.— 6. Month, D. 3.— 6. Month, D. 3.— 6. Month, D. 3.— 6. Month, D. 3.— 6. Month of the second of the se	10g. Citizen of What (10g. Citizen of What (US) 14. Race - An Black, Wh Specify: (16b. Kind of Business TRanspo 9. Maiden Sumame) Der. City or Town, State 20c. Location - City of Batho. (Batho. (Real Sumany Location - City of Control of Control Real Sumany Location - City of Control Real Sumany Location	Birthplace (State or Fo Country) 10d. Inside City Li 1 (PYes 2 Country? Personal Indian, hite, etc. 3 Lack ss/Industry 2 Lip Code) May 2 12 To Town, State 2 12 13 Approximate Interval Between Onset and Deatle
physician and point and point if item 27 is marked other than "natural", or items 23a or 28a-f show any niury or other traumatic event, the World-Examiner any niury or other traumatic event, the World-Examiner any niury or other traumatic event, the World-Examiner and process and the Complete and Process and the Complete and Com	sual Residence of Decedent Da. State 10b. County M d De. Street and Number 1 Marital Status 1 Never Married 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 7. Father's Name (First, Middle, Last) 9a. Informant's Name/Relationship (T) 9a. Method of Disposition 1 Burial 1 Donation 1 Burial 2 Cremation 1 Donation 1 Signatur Funeral Service Lice 23a. Part1. Enter the disease or condition 1 sease or condition 1 sease or condition 1 sease or condition 1 sease or condition 1 seasure (Final Service Lice 24	In a completed and the death ine cause on each line. A P I RATIO	The Yrs. Monor Continuity, Town or Location Baltim 100 St. St. 13. Was Diff Yes, 1 Tys. 16a. Decedent's (Give kind on life. Do No. 16	ths Days Hours N ORE ZIP Code Z1213 ecedent of Hispanic Origin's specify Cuban, Mexican, Property Cuban, Mexican, Property Cuban, Mexican, Property Cuban, Mexican, Property Cuban, Mexican, Property Cuban, Mexican, Property Cuban, Mexican, Property Cuban, Mexican, Property Cuban, Mexican, Property Cuban, Mexican, Property Cuban, Mexican Cuban, Property Cuban, Mexican Cuban, Construction of Control of Cuban, Control of C	(Specify Yes or N. Lerto Rican, etc.) Name (First, Middle Rence Rural Route Number Street 2 105 1039 105 1039 105	10g. Citizen of What (US 1-36 14. Race - An Black, Wr Specify: P 16b. Kind of Busines TRANSPO 9. Maiden Sumame) Der, City or Town, State ET Batto 20c. Location - City of Batto. Coardinary PARA PARA C.	Country Land 10d. Inside City Li 1 Pres 2 Country? American Indian, hite, etc. BLack ss/Industry Ptation 2 Zip Code) Mod. 212 Approximate Interval Between Onset and Deatl
bitysician and some state of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehow as the burial-transit or items 23a or 28a-f ehow and in the National Examines of the state of the sta	Da. State 10b. County 10c. Street and Number 10c. Street and Number 10c. Street and Number 10c. Street and Number 10c. Street and Number 10c. Street and Number 11c. Marital Status 11c. Never Married 11c. Decedent's Ed. 11c. Stepecify only highest grad 11c. Stepecify only highest grad 11c. Father's Name (First, Middle, Last) 11c. Father's Name (First, Middle, Last) 11c. Stepecify only highest grad 11c. Father's Name (First, Middle, Last) 11c. Stepecify only highest grad 11c. Stepecify only high	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 Yes If Yes, Give Year or Dates: Ucation le completed) College (1-4or 5+) Day Say Expe, Print) Removal from State Ca Ca Due to (or as a consequence) Due to (or as a consequence) Ca Due to (or as a consequence) Ca Due to (or as a consequence)	Baltim St. 101 St. 101 St. 110 St. 110 St. 110 St. 110 If Yes,	E. Lancal (Name of or other place) Individual Address of Facility M. McHaga h mode of dying, such as card	working Name (First, Middle RENCC Rural Route Numb e Stree Date 17/05 1639 Note	14. Race An Black, When Specify: Part Specif	nencan Indian, hite, etc. BLack ss/Industry Part Code) Town, State Co. Mi) BAHE. Ma Approximate Interval Between Onset and Deatl
physician and point and point and the point and the physician and point and	De. Street and Number C	12. Was Decedent Ever in U. Armed Forces? 1	100 St. 13. Was D If Yes, 1 Yes 16a. Decedent's (Give kind of life, DO NO BUS 19b. Mailing Add 16 33 Place of Disposition remeterly, crematory RCLOS (22. Nam M.//e h. Do not enter the BRY FAIL Juence of):	E. Lancal (Name of or other place) Individual Address of Facility M. McHaga h mode of dying, such as card	working Name (First, Middle RENCC Rural Route Numb e Stree Date 17/05 1639 Note	14. Race An Black, When Specify: Part Specif	Country? P mencan Indian, hite, etc. BLACK ss/Industry P P P P P P P P P P P P P
physician and bearing the purinent of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event. If a Marie and in any injury or other traumatic event. If a Marie and injury or other traumatic event e	1. Marital Status 1	12. Was Decedent Ever in U. Amed Forces? Amed Forces? 1 Yes 2 No 15 Yes, Give Year or Dates: College (1-4or 5+) College (1-4or 5+) Day Scarry Apperature State College (1-4or 5+) College (1-4or	St. 13. Was D If Yes, 1 Yes 16a. Decedent's (Give kind of life, DO NO) 19b. Mailing Add 16 3 Place of Disposition remetery, crematory RCLOS (22. Nam M.//e h. Do not enter the REY FAIL uence of):	ecedent of Hispanic Origin's specify Cuban, Mexican, Prospecify: Usual Occupation work done during most of Druse retired) 18. Mother's 18. Mother's 18. Mother's 18. Langual (Name of or other place) Ind Address of Facility Machanic Ma	working Name (First, Middle RENCC Rural Route Numb e Stree Date 17/05 1639 Note	14. Race An Black, When Specify: Part Specif	merican Indian, hite, etc. SLACK SS/Industry PLATICA SS/Industry PLATICA SS/Industry PLATICA ALIA APPROXIMATE Interval Batte
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event. The Marie any injury or other traumatic event. The Marie and Edical Examiner.	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 7. Father's Name (First, Middle, Last) 9a. Informant's Name/Relationship (7) 9a. Method of Disposition 12 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 11. Signature Funeral Service Lice 123a. Part1. Enter the disease or complesses or condition essulting in death) 13. Signature Funeral Service Lice 14. Signature Funeral Service Lice 15. Signature Funeral Service Lice 16. Signature Funeral Service Lice 17. Signature Funeral Service Lice 18. Signature Funeral Service Lice 18. Signature Funeral Service Lice 19. Signature Funeral S	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Joation Je completed) College (1-4or 5+) Day Say Saype, Print) Removal from State Lications that caused the death me cause on each line. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	1 Tye 16a. Decedent's (Give kind of life. Do No. 19b. Mailing Add 16a. 3 Place of Disposition remetery, crematory 22. Nam M.//e h. Do not enter the literace of):	Usual Occupation of work done during most of Druse retired) 18. Mother's I FLO Iness (Street and Number of Chame of The Place) Individual of Address of Facility Markey I mode of dying, such as card	working Name (First, Middle RENCC Rural Route Numb e Stree Date 17/05 1639 Note	Specify: Control of Business of Ranspoors, City or Town, State of Batton Control of	hite, etc. BLACK ss/Industry PLATION D. Zip Code) M. 212 Or Town, State D. MD BAHL. MA 21213 Approximate Interval Between Onset and Deat
physician and point in the marked other than and state of the marked other than and point in the marked other than any injury or other traumatic event. The marked other than any injury or other traumatic event. The marked other than any injury or other traumatic event. The marked other than any injury or other traumatic event. The marked other than any injury or other traumatic event. The marked other than any injury or other traumatic event. The marked other than any injury or other traumatic event. The marked other than any injury or other traumatic event. The marked other than any injury or other traumatic event. The marked other than any injury or other traumatic event. The marked other than any injury or other traumatic event. The marked other than any injury or other traumatic event. The marked other than any injury or other traumatic event. The marked other than any injury or other traumatic event. The marked other than any injury or other traumatic event. The marked other than any injury or other traumatic event. The marked other than any injury or other traumatic event. The marked other traumatic event. The marked other traumatic event.	3 Widowed 4 Divorced (Specify only highest grad Elementary/Secondary (0-12) 7. Father's Name (First, Middle, Last) 9a. Informant's Name/Relationship (7) 9a. Method of Disposition 12 Burial 2 Cremation 3 F 4 Donation 5 Other (Spacify) 11. Signatur Funeral Service Lice 12. Signatur Funeral Service Lice 13. Part1. Enter the disease or complesses or condition essulting in death) 14. Signatur Funeral Service Lice 15. Signatur Funeral Service Lice 16. Signatur Funeral Service Lice 17. Signatur Funeral Service Lice 18. Signatur Funeral Service Lice 19. Signatur	It Yes, Give Year or Dates: Jucation Le completed) College (1-4or 5+) Day Sc Yee, Print) Removal from State Lications that caused the death ne cause on each line. Due to (or as a consequence) APPIRATIO	16a. Decedent's (Give kind of life, Do No. But Service of Disposition remetery, crematory (RCC) 22. Nam M.//e h. Do not enter the livence of):	Usual Occupation I work done during most of I work done during most of I see retired 18. Mother's FLO Iress (Street and Number of E Langal (Name of Or other place) Ind Address of Facility Markal	Name (First, Middle REACC Rural Route Numb e 5 trze Date 17/05 1639 Note	Specify: Parties of Batton Control of Batton Carray of Batton Control of Batton Carray of Batton Carray of Batton Carray of Ca	BLack ss/Industry Rtation Rtation Rtation Rip Code) Md, 212 or Town, State O. Mi) Batto. Mi 21213 Approximate Interval Between Onset and Deat
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event. The Marie any injury or other traumatic event. The Marie and Edical Examiner.	(Specify only highest grad Elementary/Secondary (0-12) 7. Father's Name (First, Middle, Last) 9a. Informant's Name/Relationship (7) 9a. Method of Disposition 12 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 13. Signatur Funeral Service Lice 13a. Part 1. Enter the disease or complete the complete of the c	Cation de completed) College (1-4or 5+) Day Sc ype, Print) Removal from State Le Lications that caused the death one cause on each line. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	(Give kind of life, DO NO life	It work done during most of DT use retired) 18. Mother's 18. Mother's 18. Mother's 19. Language	Name (First, Middle REACC Rural Route Numb e 5 trze Date 17/05 1639 Note	TRANSPO B. Maiden Sumame) Der. City or Town, State. ET Batto 20c. Location - City of Batto. C. Batto. C. AROMANY LPRESE P. C.	p. Zip Code) , Mol, 212 or Town, State 20. Mi) Batte. Mi Approximate Interval Betwee Onset and Dea
Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. Its Marked other than any injury or other traumatic event. Its Marked other than any injury or other traumatic event. Its Marked other than any injury or other traumatic event. Its Marked other than any injury or other traumatic event. Its Marked other than any injury or other traumatic event. Its Marked other than any injury or other traumatic event. Its Marked other than any injury or other traumatic event. Its Marked other than any injury or other traumatic event. Its Marked other than any injury or other traumatic event. Its Marked other than any injury or other traumatic event. Its Marked other than any injury or other traumatic event. Its Marked other than any injury or other traumatic event. Its Marked other traumatic	Elementary/Secondary (0-12) 7. Father's Name (First, Middle, Last) 9a. Informant's Name/Relationship (7) 9a. Method of Disposition 12 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 11. Signature Funeral Service Lice 123a. Part1. Enter the disease or complete the complete or condition solution in the complete of the condition of the complete or condition is sulting in death) 13. Signature Funeral Service Lice of the condition of the condition of the condition of the condition of the condition of the conditions of the conditions of the condition of the conditions of the condition of the conditions of the condition of the condition of the conditions of the conditions of the condition of the condition of the condition of the condition of the conditions of the condition	College (1-4or 5+) Day Sc Vpe, Print) Removal from State Ca lications that caused the death ne cause on each line. Due to (or as a consequence) ASPIRATIO	BUS 19b. Mailing Add 16 33 Place of Disposition Particle of Disposition Particle of Disposition Particle of Disposition 122. Nam 11/1/e 124. Nam 125. Nam 126. Nam 127. Nam 128. Nam 128. Nam 128. Nam 129. Nam 1	IRE Mothers 18. M	Name (First, Middle REACC Rural Route Numb e 5 trze Date 17/05 1639 Note	per, City or Town, State ET Balfo 20c. Location - City of Balfo. Co Apparatury	p. Zip Code) Md, 212 or Town, State D. Mi) BAHL. YA 21213 Approximate Interval Betwee Onset and Dea
Is the buriat-transit and mental the physician	9a. Informant's Name (First, Middle, Last) 9a. Informant's Name/Relationship (T) 9a. Method of Disposition 12 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 11. Signature Funeral Service Lice 12a. Part1. Enter the disease or compleshock, or heart failure. List only of the complete of the co	Removal from State Remova	19b. Mailing Add 16 3 3 Place of Disposition cometery, crematory 22. Nam M.//e h. Do not enter the RY FAILI quence of):	Itess (Street and Number of E. Langal (Name of or other place) If faith 2 Ind Address of Facility Material Material Material Material	Name (First, Middle REACC) Rural Route Numb E 5 tree Date 17/05 1639 Note	per, City or Town, State ET Balfo 20c. Location - City of Balfo. Co Apparatury	p. Zip Code) Md, 212 or Town, State MD. MD BAHL. YA 21213 Approximate Interval Betwee Onset and Deat
physician and mental important: If item 27 is marked on the burial-transit are in positive or other traumatic even and in posi	9a. Informant's Name/Relationship (7) 9a. Informant's Name/Relationship (7) 9a. Method of Disposition 12 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 11. Signature Funeral Service Lice 12a. Part1. Enter the disease or complessory of the service of	Removal from State Remova	19b. Mailing Add 1633 Place of Disposition remetery, crematory RCLCNS 22. Nam M.//c h. Do not enter the RXY FAIL quence of):	Iress (Street and Number of E. Laneal (Name of or other place) Ind Address of Facility Metropol mode of dying, such as card	Rence Rural Route Numb e 5tre Date 17/05 1639 N. I.	Der, City or Town, State, ET Ballo 20c. Location - City of Ballo. C Ballo. C Apparatury	or Town, State O. MI) BAHO. MI Approximate Interval Between
physician and well with a physician and well well well well with a physician and well well well well well well well wel	9a. Informant's Name/Relationship (7) Da. Method of Disposition 1 ZBurial 2 Z Cremation 3 The American Service Lice of the Company of the C	Removal from State Remova	19b. Mailing Add 1633 Place of Disposition remetery, crematory RCLCNS 22. Nam M.//c h. Do not enter the RKY FAIL quence of):	Iress (Street and Number of E. Laneal (Name of or other place) J. Taith 2 J. Ind Address of Facility M. Metrapot mode of dying, such as card	Rural Route Number 5 time Date 17/05	et Balto 200. Location · City of Barto. C. apoaray pel P. C.	or Town, State O. MI) BALLE. YA Approximate Interval Betwee Onset and Dea
Department of physician and important: If it is the burial-transit are properties the burial-transit are properties and physician and important: If any injury or any inju	Da. Method of Disposition 12 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 11. Signature Funeral Service Lice 123a. Part1. Enter the disease or compleshock, or heart failure. List only of the complete of the comp	Removal from State Ca lications that caused the death ne cause on each line. RESPIRATO Due to (or as a consequence) ASPIRATIO	Place of Disposition remetery, crematory RCLOS (22. Nam M.//e.) h. Do not enter the DRY FAIL (uence of):	E. Laneal (Name of or other place) If faith 3, and Address of Facility Metropoly mode of dying, such as care	e 5 tree 17/05 1039 N. Cha	et Balto 200. Location · City of Barto. C. aroa array LPEL P. C.	or Town, State O. MI) BALLE. YA Approximate Interval Betwee Onset and Dea
Department or physician and more negronal in profession and more negronal in profession in the purial-transit and profession in the profession in the profession in the profession in the physician and profession in the physician and profession in the physician and profession in the physician and profession in the physician and profession in the physician and physic	12 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 11. Signature Funeral Service Lice 123a. Part1. Enter the disease or compleshock, or heart failure. List only of the compleshoot of the complesho	lications that caused the death ne cause on each line. a. RESPIRATO Due to (or as a consequence)	Place of Disposition cometery, crematory RCLOS (22. Nam Mille) h. Do not enter the BRY FAIL (uence of):	(Name of or other place) If faith 2 Ind Address of Facility M MCTEARS mode of dying, such as card	17/05 1039 N. B.	Batto. C. Bera day	Cor Town, State Co. Mi) Color Mi Approximate Interval Betwee Onset and Dea
bhysician and street is the buriat-transit washiner adical Examiner	23a. Part1. Enter me disease, or complete shock, or heart failure. List only of mmediate Cause (Final lisease or condition essulting in death) is equentially list conditions, any, reading to minediate ause. Enter Underlying	ilications that caused the death ne cause on each line. a. RESPIRATO Due to (or as a consequence) Due to (or as a consequence)	h. Do not enter the URY FAIL uence of):	Ind Address of Facility METROPOT mode of dying, such as care	1639 N. C.	speaking pel P.C.	21213 Approximate Interval Between Onset and Dea
bhysician and street is the buriat-transit was miner edical Examiner	23a. Part1. Enter the disease, or complete shock, or heart failure. List only of minediate Cause (Final disease or condition esulting in death) Gequentially list conditions, any, beauing to minediate ause. Enter Underlying	lications that caused the death ne cause on each line. a. RESPIRATO Due to (or as a consequence of the cons	h. Do not enter the URY FAIL uence of):	Mind Address of Facility / MCTROPE / mode of dying, such as card	Nan Cha	pel P.C.	2/2/3 Approximate Interval Betwee Onset and Dea
bhysician and street Examiner edical Examiner	shock, or heart failure. List only of minediate Cause (Final lisease or condition esulting in death) fequentially list conditions, any, leading to minediate ause. Enter Underlying	a. RESPIRATO Due to (or as a consequence of the co	h. Do not enter the IRY FAIL! uence of): IN FNEUM	mode of dying, such as card		arrest,	Onset and Dea
Physician and Medical Examiner edical Examiner	shock, or heart failure. List only of minediate Cause (Final lisease or condition esulting in death) fequentially list conditions, any, leading to minediate ause. Enter Underlying	a. RESPIRATO Due to (or as a consequence of the co	RY FAILUMENCE OF):	URE	plac or respiratory a	arrest,	Onset and Dea
physician and is the burial-transit st. the burial-transit selection is the burial-transit selection in the burial Examiner selection is the burial Examiner selection in the burial selection in the burial selection is the burial selection in the burial selection in the burial selection is the burial selection in the burial selection in the burial selection is the burial selection in the burial selection in the burial selection in the burial selection is the burial selection in the burial selection in the burial selection is the burial selection in the burial selection in the burial selection is the burial selection in the burial selection in the burial selection is the burial selection in the burial selection is the burial selection in the burial selection is the burial selection in the burial selection in the burial selection is the burial selection in the burial selection in the burial selection is the burial selection in the burial selection is the burial selection in the burial selection in the burial selection is the burial selection in the burial selection in the burial selection is the burial selection in the burial selection in the burial selection is the burial selection in the burial selection in the burial selection is the burial selection in the burial selection in the burial selection in the burial selection is the burial selection in the	esulting in death) fequentially list conditions, any, leading to minimulate ause. Enter Underlying	Due to (or as a consequence ASPIRATIO	uence of):				HOURS
physician and is the burial-transit edical Examiner	ause. Enter Underlying	ASPIRATIO	IN FNEUM				
physician and its the burial-transit edical Examine	ause. Enter Underlying	Due to for as a consequ		INTH			11/2
physicials the burners the bur	ause idisease or iniury		uance of).				
physicials the burner and call	nat initiated events esulting in death) Last	c. Due to (or as a consequ	uence of):				
G S D		4	uonos on).				
or use		d					
± 0 -19	SS. Was deceder program	23c. If yes, outcome of pregna 1□Live birth 2□Fetal		ic pregnancy		23d. Date of d	delivery
the a	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of de				Month	Day Yea
ed by the detached	art II. Other significant conditions co	ntributing to death but not res	ulting in the underhi	na cauca awan in Part I	23a Did	tobacco use contribute	to the sauce of deat
b a a	RENAL FAILURE	minuting to doubt but not rest	aning in the anaerly	ng cause given in Fait i.		1.7	Probably 4 Unk
should should leted		Z DIGEAGE			24a. Was	24h Were	autopsy findings ava
cate has been s page 2 should Completed	CORONARY_ARTERY	DISEASE			- auto	psy prior to ormed? death?	o completion of caus
重 5 0 25	5. Was case referred to medical examiner?			26. Place of I	1 ☐ Yes Death (Check only	2No 1 ☐ Ye	BS 20 No
is d	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	0#		idence 6 Other (Sp	oecify)
After this certific funeral director.	7. Manner of Death 1 Natural 5 Pending	28a. Cate of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe	how injury occurred	
	2 Accident investigation 3 Suicide 6 Could not be	Office of lating. At he	M	1 Yes 2 No	ORG Landing	(0)	
Direction by	4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	y)	ctory, office	City or To	(Street and Number or F wn, State)	Hurai Houte Number
3 5 =	9a. Certifier 1 Certifying Phy (Check only one) 1 Medicel Exami	sicien: To the best of my knowner: On the basis of examinat	wledge, death occur ition and/or investiga	red at the time, date and plation, in my opinion, death or	ace, and due to the	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
Mec Mec	9b. Signature and title of certifier	and manner stated.		29c. License number		29d. Date signed (Mor	nth, Day, Year)
4	· A.J. N	clos, M. A				February	
30	O. Name and address of person who co	ompleted cause of death (Item	n 23a) (Tyna Print)			3	, -

DHMH 17 Rev 1/2001

		State of Maryland	/ Depa	artment of H <i>tificate of L</i>	lealth and Me			5 03986	5
		Registrar 1. Decedent's Name (First, Middle, Last)		incate of L		2. Date of Dea	eg. No. th	3. Time of Death	
Physic		Mildred Emily Deise			म	Month ebruary		Year	M
/Medi Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	CDIGGI	4c. County of		_
		Manor Care Rossville		Rosed	dale		Balti	more	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day	Year)	 Birthplace (State or Foreig Country) 	gn
Director		215-09-5710 88 Usual Residence of Decedent	115.			Aug. 11	1, 1916	Maryland	
yland now		10a. State 10b. County 10c. City, T	own or Lo	cation				10d. Inside City Limits	s
B Mar	ctor	Maryland Baltimore Over	rlea					1 ☐ Yes 2 XX No	0
ith th	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of Wh	nat Country?	
s 23a	ra	17 Greenwood Avenue		21206			U.S.A.		
item Item	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No.	13. V	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Spec n, Mexican, Puerto R	ify Yes or No- lican, etc.)		- American Indian, , White, etc.	
be filed within 72 hours after death with the Maryland that Hygiene. In Hygiene. Indicate than "natural", or items 23s or 28s-f show event, the Medical Examinat must be institled at	by	3X Widowed 4 □ Divorced Year or Dates:	1	I□Yes 2XINo	Specify:		Specify:	White	
72 ho	Completed	15. Decedent's Education 1 (Specify only highest grade completed)	6a. Deced	lent's Usual Occupa	ation		16b. Kind of Bus	iness/Industry	
- c = 3	npie	Elementary/Secondary (0-12) College (1-4or 5+)			during most of working)				
filed within Hygiene. Ither than "		12th. Grade 17. Father's Name (First, Middle, Last)	Ad	minstrato	18. Mother's Name	/Final Middle		Service	
d be funtal h	Be c	Anton Hora				(Pirst, Middle,			
2 should be filed within and Mental Hygiene. Is marked other than sumatic event, the Mental Hygiene.	은		19b. Mailin	a Address (Street a	Amelia and Number or Rural	Route Number		Unknown tate. Zip Code)	
and 2:		Carolyn Lehmann/ Daughter		Letitia		altimor		21230 =	
ges 1 and 2 should tof Health and Men If item 27 is marke or other traumatic		20a. Method of Disposition 20b. Place	e of Dispos	sition (Name of natory or other place	! Da	The second second		city or Town, State	
Pages ment of h ant: If ite		Aburial 2 Cremation 3 Hemoval from State	-	f Faith	02/10/	2005	Baltimo	re MD	
permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra		21. Signature of Funeral Service Licensee	22	Name and Addres	ippel Fune	ral Hom	ne, Inc.		
- 402 00		23a Part 1 Enter the disease or complications that rays and the death 1		<u>6415 Bela</u>	air Road	<u>Baltimo</u>	ore MD	21206 Approximate	
Dissolution		23a. Part 1. Enter the disease, or complete tions that caused the death. I shock, or heart failure. List only one cause on each line. Immediate Cause (Final				105pilatory art	651,	Interval Between Onset and Death	
Physician /Medical		disease or condition resulting in death) Due to (or as a consequent of the conseque		ners T	Mease			10 YR	
Examiner			100 01).						
₽ .=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ice of):						
ecuter and trans	Examiner	that initiated events c.							
cate be executed physician and the burial-transit		Due to (or as a consequent	ice of):						
ficate be executed physician and st the burial-transit	edicai	d							
eath certifi attending for use as	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy					23d. Date	of delivery	
The law requires that the death cert ate has been signed by the attending bage 2 should be detached for use a	Physician/M	in the past 12 months? 1 Ves 2 Vin 4 Pregnant at time of death		Ectopic pregnancy Other (specify)			Mont		
res that the de signed by the a be detached to	hys	9 ☐ Unknown							
es the	by	Part II. Other significant conditions contributing to death but not resulting	ng in the ur	nderlying cause give	en in Part I.			oute to the cause of death?	
w require been signature	ted					1 🗆 Y	es 2 10 3	Probably 4 Unknown	n
e law has b	Completed					24a. Was a autops	sy pri	ere autopsy findings available for to completion of cause of	ө
vician: The certificate rector, pag	-						2 No 1	ath? ☐Yes 2☐No	
ysician: The l	o Be	25. Was case referred to medical examiner? 1 Tyes 2 Tyo Hospital: 1 Inpatient 2 TER	(0.44	Othe	26. Place of Death				
g Phy er this eral d	I	27. Manner Death 28a. Date of Injury 28	b. Time of	28c. Injury	at 28		ence 6 ∐Other ow injury occurred		_
ath. r: Afte	atio	1 ☑ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	Work M 1□	<br Yes 2 □ No				
r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office	28	3f. Location (Si City or Town	treet and Number n. State)	or Rural Route Number,	
ral Di									
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edical	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowle (Check only one) 1 ☐ Medical Examiner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the time restigation, in my op	ne, date and place, ar pinion, death occurred	nd due to the c d at the time, d	ause(s) and mani ate and place, an	ner as stated. Id due to the cause(s)	
To th within To the	Me	29b. Signature and title of continue		29c. License	number	2	9d. Date signed ((Month, Day, Year)	
4		> MUDUN		I D	744604		2/71.	5	
10		30. Name and 344000 Tposson no completed cause of death (Item 23							
		Dr. Michael Suter 9512 Harford 31. Date filed (Month, Day, Year) 32. Registra Signature				21234			
Sta Regist		FER 1 0 2005 Secure	K	Sperte					
		4.00							

			1 - For State Registrar	State of Maryland		artment of rtificate o			iene g. No. 200	5 03985
	Physici /Medi		1. Decedent's Name (First, Middle, Las Eleanor	Victoria		Eaglin		2. Date of Dea Month Februa	Day Year	3. Time of Death 9:00 萬M
	Examir	ner	4a. Facility Name (If not institution, give 611 Bonnie Me 5. Social Security Number 6. S	eadow Lane	as binds do . N	-	or Location of Dea Tashingtor ar If Under 24 Hrs	1	4c. County of De	George's
	Funeral Director			ex 7. Age (In yrs. la	Yrs.	Months Day			, 1923 Vi	irthplace (State or Foreign Country) rginia
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. I terms 23e or 28e-1 show item 27 is marked other then "neturel", or items 23e or 28e-1 show other treumatic event. The Medical Examiner must be notified at	To Be Completed by Funeral Director	10a. State 10b. County MD Prince (10e. Street and Number 611 Bonnie Meadov 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ec (Specify only highest grave) 12 17. Father's Name (First, Middle, Last) Lucien Smith 19a. Informant's Name/Relationship (1) Vernada Batts - I	George's For V Lane 12. Was Decedent Ever in U.S Armed Forces? 1 1 Yes 2 Ten No If Yes, Give Year or Dates: Uccation de completed) College (1-4or 5+)	16a. Deced Give life. Home	Nas Decedent of Yes, specify Co	f Hispanic Origin? (suban, Mexican, Puero Specify: upation e during most of worked) 18. Mother's Na Lelia et and Number or R	Specify Yes or No- to Rican, etc.) rking me (First, Middle, M Smith ural Route Number,	City or Town, State,	nerican Indian, ite, etc. Black s/Industry
Baltimore,	permit. Pages 1 and 2 Department of Health Importent: If item 27 I any injury or other tre 2005.		20a. Method of Disposition 1 \$\mathbb{Z}\$ Burial 2 \$\mathbb{C}\$ cremation 3 \$\mathbb{C}\$ '4 \$\mathbb{D}\$ Donation 5 \$\mathbb{D}\$ Other (Specify) 21. Signature of Funeral Service \$\mathbb{L}\$ en	Removal from State Cul	ce of Dispo netery, crer peper	sition (Name of natory or other p Nationa Name and Ado Bailey	lace) 1 2-8 Iress of Facility Funeral F	Date S-05 Iome	Culpeper, icksburg,	r Town, State VA
8760, <	death certificate be executed A granding physician and indicate as the burial-transit of for use as the burial-transit	Ical Examiner	23a. Part Enter the disease, or comprished, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. End Stage Due to (or as a conseque c. Atrial Fib Due to (or as a conseque Chronic Ob Country (or as a conseque Congestive d. Congestive	Renal nce of): struc nce of): rilla nce of):	Disease tive Pul	e Lmonary D:		est,	Approximate Interval Between Onset and Death
P.O. Box 68	that the death certifica led by the attending ph detached for use as ti	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal d 4 Pregnant at time of dea 9 Unknown	eath 3⊑ th 5⊡	Ectopic pregnan Other (specify)			23d. Date of de Month	Day Year
ords,	requires een sign oould be	eted by	Part II. Other significant conditions of	ontributing to death but not result	ing in the ur	derlying cause (piven in Part I.			o the cause of death?
Vital Record	The larate has	e Completed	25. Was case referred to medical					24a. Was ar autops perform 1 Yes 2	prior to	utopsy findings available completion of cause of
Division of Vit	or Attending Physici fter death. Director: After this cer in by the funeral direct	ertification; To Be	examiner?	28a. Date of Injury (Month, Day Year)	P/Outpatien 8b. Time of Injury e, farm, str	28c. Inj W M 1 [ther: 4 Nursing I ury at ork? Yes 2 No	28d. Describe ho	nce 6 Other (Spewinjury occurred	
	Hospite 4 hours Funerel ely filled	edical Ce	29a. Certifier 1 Certifying Phyone) 1 Medicel Example 2 Medicel Example 2	ysicien: To the best of my knowl iiner: On the basis of examinatio and manner stated.	edge, death n and/or inv	occurred at the restigation, in my	time, date and place opinion, death occu	, and due to the ca	use(s) and manner a te and place, and du	s stated. e to the cause(s)
•	To the Hos within 24 h To the Fur	Me	29b. Signature and title of certifier	Zionous		D	nse number		ed. Date signed (Mon 2-3-05	th, Day, Year)
1	Sta Registr		30. Name and address of person who of Violet Habwe, MD 31. Date filed (Month, Day, Year) 200	730 24th Stre	et NW	Washing	ton, DC 2	0037		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Lillian Engelbrecht February 09 /Medical 2005 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Medical Center Mercu Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/8/20 **Funeral** 9. Birthplace (State or Foreign 1 M 2 F Director 218-07-0682 MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Exercines must be notified at 10d. Inside City Limits Director 1X Yes 2 □ No MD N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death wi and Mental Hyglene. Is marked other than "natural", or items 23a o 700 S. MONTFORD AVE. 21224 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ If Yes, Give Year or Dates: 3

Widowed 4 □ Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 OFFICE WORKER STATE OF MARYLAND 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANTON KRUTSCH ANNA KORSCH permit. Pages 1 and 2 should I Department of Health and Meni Important: If Item 27 is marker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AURORA, ILLINOIS 60506 MR. ROBERT A. VINSON 818 OAK AVE. 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State OAK LAWN CEME. 1 Burial 2 Cremation 3 Removal from State in ury or * 4 ☐ Donation 5 ☐ Other (Specify) 2/12/05 BALTIMORE, MD. 21. Signature of Funeral Service Licens KACZOROWSK Facil FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTIMORE, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Kesbiratory /Medical Examiner Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical as the attending nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery jo 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) the Division of Vital Records, P.O. δ Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Obstructive Pulmonary 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 autopsy performed 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deati To the Funeral Director: completely filled in by the 6 Could not be determined 3 T Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18568 2005 completed cause of death (Item 23a) (Type, Print) 301 St. Paul St. Baltimore, MD 21202 31. Date filed (Month, 32. Registrar Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Marie Ruzicka Gross Feldmann 2:20 A M February 8 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 204 Brightwood Club Dr. Lutherville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Director 98 Yrs 316-07-4956 March 6, 1906 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show rel', or items 23a or 28e-f shov Examiner must be prefilled at Baltimore Maryland Lutherville Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 204 Brightwood Club Dr. 21093 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after THEO Polces: | ☐ Yes 2 1 No | Yes, Give | Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 Yes 2 No þ Specify: 3XXWidowed 4 Divorced "neturel", d other than "neture event, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ company owner book binding 27 Is marked other r treumetic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Ruzicka Nellie Eva Kahl 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health lem 27 I J.M. Dryden Hall, Jr./Executor 6510 Falls Rd. Baltimore, MD 21.209 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H
Importent: If ite
eny injury or ot
once. IXBurial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cemeter Feb. 17,2005 Woodlawn, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, our O. Mitchel 6500 York Rd. baltimore, MD 23a. Ber 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** yourland /Medical Due to (das a consequence of) Examiner Himestern Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (as a consequence of): Examine death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day 4□Pregnant at time of death 5 Other (specify) P.O. I ed by the a detached f 9 Unknown requires that the 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performed? certificate 1 Yes 1 🗌 Yes 2 No or Attending Physiclen: director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel L Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year)) West Mus 2/9/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WEGLEIM 6569 N. CHARLES 5+ A411 BAUTO NON PUD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 0 2005 Registrar

DHMH 17 Rev 1/2001

Amend Item#105 per FH, 6341, 3/23/05 Higher the Copies Are Legible. 1- State Registra MEND TTFM #5 PER FH C840 2/15/05 JH 3000 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Wilmer Jack Fitzwater Feb. 6 2005 9:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 14729 Oak Orchard Road New Windsor Carroll FREDERICK | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 2, 1932 5. Social Security Number 212-30-6491 Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 124M 2□F Director Yrs 72 Maryland Usual Residence of Decedent with the Maryland 10b. County Frederick 10a State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Exeminer must be notified at Director Carroll Maryland New Windsor 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 14729 Oak Orchard Road 21776 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠ Yes 2 □ No 1953 − 1955 Year or Dates: 1955 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Meniai Hygiene. snt: If Item 27 Is marked other than "natural", or Itel 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No à Specify: 3 ☐ Widowed 4 ☐ Divorced White 1955 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Machine Operator Western Electric Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilmer George Fitzwater Catherine A. Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14729 Oak Orchard Road New Windsor, MD Lorraine Fitzwater wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Bunal 2 ☐ Cremation 3 ☐ Removal from State 9, ö permit. Page Department of Important: If any Injury or once. Feb. 4 ☐ Donation 5 ☐ Other (Specify) Taylorsville Cemetery 2005 Taylorsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory, PA
1912 II Old Liberty Road Winfield, MD 21784 29a. Part. Enter the disease, or complications that dayed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause or each line. Approximate Interval Between ardionyoputhy Onset and Death Immediate Cause (Final **Physician** Schemic disease or condition resulting in death) ear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical The law requires that the death certificate the attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autoosy performed 21**24**10 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes To the Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 10 1 ☐ Yes 2 💆 🗥 o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Ratural 5 Pending death. 1 Yes 2 No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

MD

Stoner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

31. Date filed (Month, Day, Year)

D9058137

	1 - For State Registrar	State of Maryland / D	Department of Health and Certificate of Death	•	2005 03001
Physician /Medical Examiner	Durryren	street and number)	4b. City, Town, or Location of Deat Glen, Burnie	120	Day Yeer 3. Time of Death 4. 49 M 4c. County of Death Anne Arundel
Funeral Director	Usual Residence of Decedent	20F 63 Y	rs. Months Days Hours Min.	8. Date of Birth (Month, Oay, Yea	
ith the Marylar or 28e-f show a rutilled at	10a. State 10b. County MD Anne A 10e. Street and Number	trundel Glen	Or Location U (N) () 10f. Zip Code	10g.	10d. Inside City Limits 1 ☐ Yes 2X No Citizen of What Country?
036 urs after death w urs, or items 23e raring in thinstill by Funeral I	3 ☐ Widowed 4 ☐ Divorced	Jack Road 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ②SNo If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen 1 Yes 22 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
d 21215-0036 filed within 72 hours aft Hygiene. other then "natural", or ant, the Medical Exerci-	15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work done during most of work life. DO NOT use retired) Enager/Doorman 18. Mother's Nar	king 16b.	Restaurant/Night Clui
Maryland 212: d 2 should be filed within th and Mental Hygiene. i? is marked other then treumatic event, them To Be Comp	Joseph Lanaza		Petty Mailing Address (Street and Number or Ru	Uhk.	y or Town, State, Zip Code)
Baltimore, M permit. Pages 1 and 1 Department of Health Importent: if item 27 eny injury or other tr.	20a. Method of Disposition 1 ☐ Burial 2XX Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify 21. Sonature on uneral Service Line)	Removal from State 20b. Place of cometery BayVie		Date 20c. 8, 2005 E	21226 Location - City or Town, State Paltimore Maryland
1760, ate be executed ate be executed Aystotan and he burial-transit local Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due t	ot enter the mode of dying, such as cardiac Arry Atrus f):		Approximate Interval Between Onset and Death
The law requires that the death certificate are has been signed by the attending physpage 2 should be detached for use as the completed by Physician/Medical		d	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
cords, P. w requires that the pean signed by should be detailed by Philippe peans to be pe	Part II. Other significant conditions co	ntributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
Vital Records, itien: The law requires t certificate has been signe rector, page 2 should be	25. Was case referred to medical		26. Place of Daa	24a. Was an autopsy performed? 1 Yes 24a	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Phys this ald dil	1 ☐ Yes 2 DNo		Other: 4 Nursing H me of 28c. Injury at Work? M 1 Yes 2 No	ome 5 Residence 28d. Describe how inj	jury occurred
Division To the Hospitel or Attending within 24 hours after death. To the Funerel Director. After completely filled in by the funer Medical Certification	4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify) sician: To the best of my knowledge,	death occurred at the time, date and place	City or Town, Sta	(e) and manner as stated
To the Hospitel within 24 hours: To the Funeral completely filled		ner: On the basis of examination and and manner stated.	29c. License number D 005702	red at the time, date a	ond place, and due to the cause(s) Date signed (Month, Day, Year)
State Registrar	31. Date filed (Month, Day, Year) FEB 1 0 20	ompleted cause of death (Item 23a) (I MD GOU RI GGE 32. 100 Mg and	ype. Print) Ply Ave Sylle 231	Annapo	115,4021401

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla	and / Depa	artment c	of Health and of Death	Mental Hy	giene Reg. No. 20	05 0399
	Physici /Medic		1. Decedent's Name (First, Middle Last)	pman				2. Date of Dea	Day 105	3. Time of Death
	Examir		4a. Facility Name (If not institution, give s	street and number) Q 7. Age (In y.	rs. last birthday)	If Under 1 Y	wn, or Location of Dea	S. 8 Date of Birt	4c. County of	Birthplace (State or Foreign Country)
Р	Director Mout		578-50-5396 Usual Residence of Decedent 10a. State 10b. County		Yrs. City, Town or Lo	ocation		Oct. 16	5, 1938	New York 10d. Inside City Limits
with the Ma	3a or 28a-fi It be notifie	Funeral Director	VA Frederic 10e. Street and Number 1082 Lakeview D		Cross J	10f. Zip Co			10g. Citizen of Wha	1 ☐ Yes 2 € No
G Z I Z I 3-UU30 filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23a or 28a-f show my righty or other traumatic event, the Medical Examiner must be notified at ance.	à	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent If Yes, specify	of Hispanic Origin? (Cuban, Mexican, Pue No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Black, '	American Indian, White, etc. White
Z1Z15-UU30 od within 72 hours af	jiene. r than "natur Ine Medical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give life.	dent's Usual O kind of work d DO NOT use re d Engir	lone during most of wo etired)	orking	16b. Kind of Busin	
Maryland of tilec	d Mental Hyg narkad othe natic event,	To Be C	17. Father's Name (First, Middle, Last) Walter B. Free				18. Mother's Na Greta	a Nisser	<i>Maiden Sumame)</i> 1	
ore, Mal les 1 and 2 st	of Health and If itam 27 is n or other traun		19a. Informant's Name/Relationship (Ty, Mr. Robert D. Free! 20a. Method of Disposition 1□ Burial 2X□ Cremation 3□R	man (Son)	6182 o. Place of Dispo cemetery, crei	River E		, Manassa Date		112
Baltimore,	Department Important: any injury conce.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	A			nation 2/10 FUNERAL HO ille, MD 2	and the second s	Sykesvil: APEL, PA 0)-795-140	
1	nysician Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the de ne cause on each line. a. ue to (or as a cons	eath. Do not ent					Approximate Interval Between Onset and Death Manth S
	daminer susit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	equence of):			-		
ob rou, /	physician and s the burial-transit	cai	resulting in death) Last	Due to (or as a cons	equence of):					
the death cert	signed by the attending ph d be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of prec 1 □ Live birth 2 □ Fr 4 □ Pregnant at time o 9 □ Unknown	etal death 3 [Ectopic pregn Other (specif			23d. Date o Month	f delivery Day Year
Prus, r	been signed b should be deta		Part II. Other significant conditions con	ntributing to death but not r	esulting in the u	nderlying cause	e given in Part I.	23e. Did to		te to the cause of death? Probably 4 ☐Unknown
VILAI MECOFO sician: The law requir	SO	Completed	OF Was now returned to modified						sy prior med? dear 2540 1□	e autopsy findings available r to completion of cause of th? Yes 2 \(\sum \text{No} \)
ding Phy	ith. : After this certificate ha s funeral director, page	tlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death Natural 5 Pending investigation	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of	28c.	Othor	7	ence 6 Other (Specify)
	within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe	cify)	•		City or Tow	n, State)	r Rural Route Number,
To the Hospital or	within 24 hor To the Fune completely fi	Medical	(Check only 2 Medicel Examir one)	sicien: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death ination and/or in	vestigation, in r	my opinion, death occ	urred at the time, o	date and place, and	due to the cause(s)
To	To cor		29b. Signature and title of deptifier	le mo		29c. Lie	0958 (7	37	$\frac{29d}{2/8}$ Date signed (M	onth, Day, Year)
	П		30. Name and address of person who so	295 Sto	ner A	Print)	307 W	restonin	ster M	0 2157
	Sta Registr	_	31. Date filed (Month, Day, Yeer) PEB 1 0 20	32. Fullstran's Sig	mature	hick				

			State of Maryland / Dep 1- State Unpend Itemn 23a,27,28a-f per ma		•		03993		
			Decedent's Name (First, Middle, Last)		2. Date of Death	g. 140.	3. Time of Death		
	Physici		Matthew Kyle Flynn		FEBRUARY	Z 6, 2005	6:15 P [™]		
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	0.101		
	LXamiii	-	ST AGNES HOSPITAL	BALTIMORE CITY		n/a			
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	/) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthp	lace (State or Foreign		
	Director		215-23-7759 1 [™] 2□F 23 Yrs.	Months Days Hours Min.	May 20,	1981 Mar	yland		
	PE		Usual Residence of Decedent						
	show	L	10a. State 10b. County 10c. City, Town or I	Location		1	0d. Inside City Limits		
	89-1 s	cto	Georgia Forsyth Cumm	ing			1 ☐ Yes 2 ☑ No		
	or 24	Dire	10e. Street and Number	10f. Zip Code	109	g. Citizen of What Cour	-		
	within 72 hours after death with the Maryland ene. than "neturel", or Items 23e or 28e-f show the Madical Everthet rest be trufflind at	Funerai Director	2810 Cobblestone Drive	30041		United St			
	tems	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,			
36	s afte	by Fi	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2x No Specify:		Specify: TTI-			
0	hour ture!	d b		adontia Hausi Ossusation	1 4		ite		
<u>7</u>	n 72	iete	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of wor DO NOT use retired)	king	6b. Kind of Business/Inc	JUSTry		
12	withi ene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Home Improvements		Construc	tion		
0	be filed ntal Hygie od other event, II		17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma				
an	ld be ental ked c	To Be	Edward John Flynn, Jr.	Lorie	Battaglia				
Maryland 21215-0036	should nd Men marke umatic	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Ru	ral Route Number, (City or Town, State, Zip	Code)		
	nd 2 Ilth a 27 is r tret		Mr. & Mrs. Edward Flynn Parents 700	3 Fox Chase Road	New Marke	t, MD 217	74		
æ,	os 1 and 5 Health item 27		20a. Method of Disposition 20b. Place of Disposition		Date 20	Oc. Location - City or To	wn, State		
Baltimore,	Page ent c nt: If		I L Burial 2 Literation 3 Literature I literature I	arroll Crematory F	eb. 7, 20	05 Winfiel	d. Maryland		
Ħ	permit. F Departm Importer any inju	1		22. Name and Address of Facility					
ä	permi Depa Impo any it		John 12 Caller	Burrier-Queen Fun 1212 W. Old Liber	eral Home	e & Cremato: Winfield	ry, PA MD 21784		
			22 Part1. Inter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between		
	Pnysician :	1	Immediat Cause (Final				Onset and Death		
	/Medical	(disease r condition resulting in death) Due to (or as a consequence of):	and methylenedioxy	шеспашрпе	tamine /int	JAICACION		
В	Examiner								
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	10					
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events c.		-				
o,	an ar rial-tı		resulting in death) Last Due to (or as a consequence of):						
760,	<u> </u>	icai	d						
68	death certifica le attending ph ed for use as th	Jed	IF FEMALE:		-				
Box	th ce endi	an/l	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	☐Ectopic pregnancy		23d. Date of delive	-		
Э. П	s dea he at ed fo	sici	1 Yes 2 No	Other (specify)		Month	Day Year		
P.O.	that the death certifical ed by the attending phi detached for use as th	Physician/Med	5 CHRIOWII						
	es gn be	by I	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to th	1. 4		
ord	v requir been si should	ted			1 L Yes	2 No 3 Prob	ably 4 Unknown		
ec	e lawr has be je 2 sh	pie			24a. Was an autopsy	prior to cor	psy findings available inpletion of cause of		
<u>س</u>		Completed			performe 1 X Yes 2		2□ No		
Vital Records,	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?		th (Check only one)				
of \	ding Physician: After this certific funeral director,	은	XXYes 2 ☐ No Hospital: 1 ☐ Inpatient 2XX R/Outpatie	the same name to the first to the		ce 6 ☐Other (Specify)		
ū		on:	27. Manner of Death 1 □ Natural 5 □ Pending	Work?	28d. Describe how	injury occurred	unk		
sio	Attending r death. sctor: After y the fune	cati	2 Accident investigation 2-6-05 7:29	PM 1 Yes 2 X NO					
Division	l or Attendatter deatt Director:	Certification:	4 Homicide building, etc. (Specify)	street, factory, office	City or Town,	et and Number or Rura State/ 7033 Fox	Chase Rd.		
	Hospitel or 24 hours afte Funerel Dir tely filled in		Found at home		new Harke	et, Mu			
	Hoss 24 ho Fune Fune	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea (Check only one) Ameliana Examinar: On the basis of examination and/or in and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occur	, and due to the cau red at the time, date	se(s) and manner as st e and place, and due to	ated. the cause(s)		
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Med	one) 22 and manner stated. 29b. Signature and title of certifier	29c. License number	290	I. Date signed (Month, i	Day, Year)		
	F 18 F 8		DA DA	OCME		FEBRUARY 7,			
7			20 Name and address of agent who completed are at dark the			,			
			30 Name and address of person who completed cause of death (Item 23a) (Type	111 PENN STREE	C, BALTIMO	ORE, MARYLA	ND, 21201		
	. Sta	to.	31. Date filed (Month, Day, Year) 32 Registrar's Signature	N. S.					
	Registr		FEB 1 0 2005 Line 16 19						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amen ditem#12 perFh 6840 2/10/05 TT State of Maryland / Department of Health and Mental Hygiene 0 0 5 113994 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY **FEINBERG** 5, 2005 8:50 A IRVING 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE JEWISH CONVALESCENT CENTER BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 05/19/1923 5. Social Security Number 6. Sex 10 M 2 F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 81 088-12-9765 N.Y. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 📉 No MD BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7920 SCOTTS LEVEL ROAD 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1♥ Yes 2 (1) No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE Specify: 3 Nidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) OWNER RETAIL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **FEINBERG** HENRY ADA LEVINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12128 VELVET HILL DRIVE OWINGS MILLS, MD 21117 MICHAEL FEINBERG / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State BETH DAVID 02/13/2005 ELMONT, N.Y. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one pause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHERDSCLEROTIC Sequentially list conditions, it any, loading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (ur as a our sequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE:

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

or 28e-f show

or Items 23a

the Medical Examiner must be notified at

other treumatic event,

by Funeral Director

Be Completed

2

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Il Hygiene.

f Health and Mental item 27 Is marked o

ō = 5

Baltimore, Maryland 21215-0036

Examiner Completed by Physician/Medical Be ပ္ Certification;

Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospitel within 24 hours a To the Funerel C

> State Registrar

Medical

29b. Signature and title of certifier

ASNEEM

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 1 0 2005

32. Regist

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23d. Date of delivery Month Day Year							
Part IT. Other significant conditions of the State of the	contributing to death but not resulting in the underlying cause given in Pa	art I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Denknown						
CORONARI	y ARITRY DISEASE	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No						
25. Was case referred to medical	26. Place of Death (Check only one)							
examiner? 1 Yes 2 THO	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑	Nursing Home 5 Residence 6 Other (Specify)						
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28d. Describe how injury occurred □ No						
3 Suicide 6 Could not to determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	hysicien: To the best of my knowledge, death occurred at the time, date miner: On the basis of examination and/or investigation, in my opinion, or and manner stated							

29c. License number

3859S

29d. Date signed (Month, Day, Year)

BALD MD 2pos

r's Signature

7220

ΥI			1- For Unpend Item Registrar	23a,27,2	Maryland / 8a-f per	Depa me Cei	artmen G840 rtificati	5053 e of l	ealth a	and Me	ental Hyg	iene	005	039	95
	Dhusia		1. Decedent's Name (First, Middle,							1 3	Date of Deat	h		3. Time o	of Death
	Physic /Medi		Christopher All	Lan Felts	an Felts				FÉBRUAR	Υ ⁵ 5,	2005	2:03	Рм		
	Exami	ner	4a. Facility Name (If not institution, 97227 HOLABIRD A					Town, or INDAI	Location of	of Death			ounty of Deeth		
ĝ	Funeral Director		220-88-3681	.Sex 7 1∭XM 2☐F	. Age (In yrs. last t	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	B. Date of Birth (Month, Day, pril 30	Year) 19	9. Birth Con 77 Ma	nplace (State untry) ryland	or Foreign
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location													1	10d. Inside C	City Limits
	Man Miled	ţċ	Maryland Baltin	nore	Dund	la1k								1 🗀 Yes	2 X No
	ith the	Director	10e. Street and Number				10f. Zip	Code			10	0g. Citize	n of What Cou	untry?	
	ath w		7227 Holabird Av	enue			2	21222	2			U.S	Δ		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or items 23a or 28e-f show simportent: if item 27 is marked other then "natural", or items 20a or 28e-f show any injury or other traumatic event, the Modical Examinar must be notified at ONEs.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Force	M No	1	Was Deced fYes, spec 1 ☐ Yes 2		spanic Ori n, Mexicar Specify:		fy Yes or No- can, etc.)	14	Race - Amer Black, White		
5-0	72 ho	Completed	15. Decedent's (Specify only highest of	Education	16	ia. Deced	ient's Usua	I Occupa	ition	t of working		16b. Kind	of Business/I		-
21	vithin ne.	mpje	Elementary/Secondary (0-12)	College (1-4	lor 5+)	life. L	DO NOT us	e retired))	t or working	'				
	illed v Hygie ther t nt, tt	ပိ	12 Years 17. Father's Name (First, Middle, La	N/A		Fork	lift	Oper			Fi- 1 1 1 - 1 - 1		ehouse		
Maryland	d be f antal l ced of	o Be	Michael Felts	31/							First, Middle, N		mame)		
Σ	should nd Me mark mati	ို	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailin	a Address	(Street a	Mar Mar	garet eror Bumili	Hagger Route Number,	City or T	oum State 7	in Code)	
	nd 2 alth ar		Heather Felts	, ,, ., .,			Hola				ltimore				
altimore,	item item othe		20a. Method of Disposition	_	20b. Place	of Dispos		e of		Dat			21222 tion - City or T		
Ë	Page nent c nnt: If iry or		1 Z Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec		are i	-	islau		′	2/10/0)5 1	Dund:	ılk, MI	`	
Balti	permit. Departr Importe any inju		21. Signature of une of Service Lic	ensee		22	Name and	d Address	s of Facilit	by.	neral Balti			21224	
			22a. Part1 Enter the disease, or co shock, or heart failure. List on	mplications that cau	sed the death. Do	not ente	er the mode	of dying	, such as	cardiac or r	espiratory arre	st,	. rid 2	Approximation Interval Bet	te
1	Physician		Immediate Cause (Final disease or condition		and Eth									Onset and	Death
	/Medical- Examiner		resulting in death)	as a consequence					·						
	LAMITIME	L .	Sequentially list conditions,	b Due to (or as a consequence of):											
	led isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence	9 of):									
	cate be executed oblysician and the burial-transit	that initiated events resulting in death) Last	c Due to (or	as a consequence	e of);										
8760,	cate be ex physician the buria	dicai E	· ·	. d		,									
9		ledic		u.											
P.O. Box	ne death cer the attendir thed for use	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 Fetal death		Ectopic pre Other (spe					23d	. Date of deliv Month	-	Year
	es that thighed by	y Pt	Part II. Other significant conditions	contributing to deat	h but not resulting	in the un	derlying ca	use givei	n in Part I.		23e. Did toba	acco use	contribute to t	he cause of c	death?
rds	w requires been sign should be	ed b									1 🗆 Yes	2 PK	o 3 Proi	babiy 4 ⊡t	Jnknown
Records,	law re as bec 2 sho	Completed									24a. Was an		4b. Were auto	opsy findings	available
B	The la ate ha	E O						-			autopsy perform 1927es 2	ed?	prior to co death?	impletion of c 2□ No	ause of
Vital	d cien : Th certificate ector, pag	Be (25. Was case referred to medical examiner?						26. Place	of Death (C	Check only one		1	20140	
of \	Physicien: this certific ral director,	P	XXYes 2□ No	Hospital: 1 Inp				-	4 🗆 1401	rsing Home	5 🗆 Residen	ice 6X	Other (Specia	SCEN	E
ou c		lon	27. Manner of Death 1 □ Natural 5 □ Pending	Found	njury Day Year) 38 b.	Time of 03	At 28	c. Injury	?		I. Describe how	v injury o	curred	ınk	
Division	Attending r death. ector: After by the fune	cat	2 Accident Investigation 3 Suicide 6 Could not	2-5-05				1 🗆 Y	es 🛣 🗆 N		Landin (2)				
Ö	spitel or A ours after nerel Direc filled in by	Certification;	4 Homicide determine	building,	Injury - At home, for etc. (Specify) At Reside	ORCO	et, lactory,	OHICO		-	Location (Stree City or Town,	State)7	227 Ho1	labird	Ave.
	a Hospitel or Attent 24 hours after death Funerel Director; etely filled in by the	a C	29a. Certifier 1 Certifying P	hysicien: To the be	st of my knowledg	e. death	occurred a	t the time	date and	I place and	indalk,	150/5) 20	l mannar as a	tated	
	To the Hos within 24 h To the Fur completely	edicai	(Check only 2 Medical Exe	eminer: On the basis and manner	s of examination ar	nd/or inve	estigation,	n my opi	nion, deat	h occurred	at the time, dat	e and pla	ce, and due to	o the cause(s)
	To the within 2 To the complet	Z	29b. Signature and title of certifier	11	\sim			License O C			290		gned (Month, RUARY 6		5
-			30. Name and address of person why	completed cause of	of death (Item 23a)	(Type, P		PEN	N STE	REET,	BALTIM	ORE,	MARYLA	AND, 21	L201
***	Sta Registr	_	31. Date filed (Month, Day, Year) FEB 10	2005 32. R	strar's Signature	A	mile	,							

amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#17.perFH_G840.2/10/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death edent's Name (First, Middle, 2. Date of Death 3. Time of Death Year **Physician** 550PM EBRUARY 06, 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** timor 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Director 1aut Usual Residence of Decedent 10a. State 10b. County City, Town or Location 10d. Inside City Limits 28a-f shoy event, the Medical Examiner must be notified at 1 Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? or items 23a or Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ☐Yes 2 No 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced "natural". 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working the DO NOT use retired) 16b. Kind of Business/Industry ages I and 2 should be filed within 7 and of Health and Mental Hygiene.

N: If item 27 is marked other than "n y or other traumatic event, the Med College (1-4or 5+) IVE Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) Thomas Gray 19b. Mailing Ad ss (Street and Number or Rural Route Number or Town, State, Zip Code) Osedalo, MT Ob. Place of Disposition sposition Pages Burial 2 Cremation permit. Page Department of Important: If any njury or 4 ☐ Donation 5 ☐ Other (Specify) to. MEROHL 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of d shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** UNGESTIVE HEART FAILURIS 4 EAR /Medical Due to (or as a consequence of): Examiner SCHEMIC CARDIO 1940 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) executed use as the burial-transit and Due to (or as a consequence of): Box 68760, Iding physician or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ed by the attended for us 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9☐ Unknown 9 🗍 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ě ORONYARY DISISASIE 1 Yes 2 No 3 Probably 4 Waknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Ne 24a. Was an page 2 autopsy this certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐-No 1 Topatient 2 ER/Outpatient 3□ DOA Date of Injury (Month, Day 28c. injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 -Natural Injury 1 ☐ Yes 2 ☐ No death. Director: 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral C 1 Peritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one the e 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MAS D47123 FEBRUARY OG 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MENGORIAL HOSPITAL, BACTIMORE PUTHUNGONA, UNION 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 La Maria Registrar 0 2005

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla		artment of rtificate of			giene Reg. No.O A C) ***
	Physic /Medi		1. Decedent's Name (First, Middle, Last, Lester H.	Gerner				2. Date of De. Month Februs	ury 9, 201	3 1 ing of beath 7
	Examir		4a. Facility Name (If not institution, give Hospice of Baltimore (street and number) Gilchrist Cente	r	4b. City, Town,	or Location of D	eath	4c. County of Baltir	
	Funeral Director			7. Age (In yi	s. last birthday) Yrs.	If Under 1 Yea Months Days		Hrs. 8. Date of Birt Min. (Month Da April 16		Birthplace (State or Foreign Country) ISCONSIN
	e Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Baltim		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the	ai Director	10e. Street and Number 1 Smeton Place, U	nit 1402		10f. Zip Code 21 204			10g. Citizen of What	at Country?
9036	within 72 hours after death with the Maryland ane. than "neturel", or Items 23a or 28a-f show the Medical Eventher mast ke notified at	d by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 XYes 2 No W If Yes, Give Year or Dates:	ıııı '	Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 🔀 No	ban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)		American Indian, White, etc. White
21215-0036	100 E. L. Sell.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work doni OO NOT use retir	e during most of	working	16b. Kind of Busin	
Maryland	D = 0 0	To Be (17. Father's Name (First, Middle, Last) Emil	Gerner				Name <i>(First, Middl</i> e, J isa		reund
	nd 2 shu lith and 27 is m r traum		19a. Informant's Name/Relationship (Ty Constance Gerner-u	•				r Rural Route Number 1402, To		ate, Zip Code) 21 204
Baltimore,	Pages 1 ar		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State		sition (Name of natory or other pl Ley Mem; 1		Date /12/05	20c. Location - Cit	
Balti	permit. Pages Department of Himportant; if ite any injury or of once.		21. Signature of Funeral Service kicens	∞ William G.D				Luck Towson Forn, MD 2121	uneral Home	
8760,	/Medical Examiner the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line.	equence of):		ing, such as car	glac or respiratory ar	rest,	Approximate Interval Between Onset and Death CCCCS
.O. Box 6	death certifi e attending id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	taldeath 3 [Ectopic pregnand Other (specify)	гу		23d. Date o Month	
<u>α</u>	w requires that the been signed by th should be detache	5	Part II. Other significant conditions cor	ntributing to death but not re	esulting in the ur	nderlying cause g	iven in Part I.	23e. Did to		ite to the cause of death? ☐ Probably 4 ☐Unknown
al Records,	The law ate has b page 2 s	Completed						24a. Was a autop perfor	sy prio red? dea	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
Division of Vital	ding Phys h. After this funeral di	ation: To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 New Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju	her: 4 🗆 Nursin	Death (Check only or g Home 5 ☐ Resid 28d. Describe h		(Specify) MOSPICE
Divis	s after death s after death al Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre city)	eet, factory, office		28f. Location (S City or Tow	treet and Number on, State)	or Rural Route Number,
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my kiner: On the basis of examinand manner stated.	nation and/or inv	estigation, in my	opinion, death o	courred at the time of	late and place, and	due to the cauco(c)
):	To the I within 2. To the I complet	N	29b. Signature and title of certifier	and manner stated. Impleted cause of death (Ite. 2005 32. Reg , ar's Sign	>	29c. Licen	se number 5 3 3 3 3 3	F	egnuary	Month, Day, Year)
1	164)		30. Name ind address of person who co	impleted cause of death (Ite	em 23a) (Type,	Print)	+ Ral	truce n	52120	4
	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 0	2005 ^{32. Registar's Sign}	nature #	Sperle	1			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Febr 2005 10:30 + rache tranci Jan /Medical c. County of Deeth 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner WNDAIK Bettimore 37 Benksh 15C 5. Social Security Number If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 5,1923 Birthplace (State or Foreign Country)
 MD 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □XM 2 □ F Days Hours Yrs. 215-18-6008 Director 81 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State r 28a-f show 10h Counts 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Dundalk MD. Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 7437 Berkshire Road 21222 USA Funeral filad within 72 hours aftar daath ırai', or itams ? I Examiner mu 12. Was Decadent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □XYes 2 □ No If Yes, Give 1 Never Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2\times\text{No Specify: Specify: White <u>^</u> 3XWidowed 4 □ Divorced 'naturai', Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5 years Maintenance Technician Apartment Complex 7 Is marked other traumatic event, 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be and Mantal Frances Petter John Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 1845 Portship Road, Dundalk, Md. 21222 Dianne Boddice daughter altimore, ages
__opartment of Ht.
Important: If Itam.
any injury or cet.
once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State February 8, 2005 Rosedale, MD. 4 ☐ Donation 5 ☐ Other (Specify) Cardens of Faith Cemetery 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 sollers point Road, Dudnalk, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner Tha law requires that the death certificate be executed bunial-transit physician and s the bunal-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) attanding pl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 9 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes aftar death.

Director: After this cartification by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Hesidenca 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No မှ 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Hospital or Attanding 5 Pending 1 Offiaturel 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) filled in by 4 I Homicide within 24 hours a

To the Funeral C

completaly filled 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as steted. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ŝ

> UND

-och

L

Registrar's Signature

Ravin

29d. Date signed (Month, Dey, Yeer)

0055035

Bld Baltimor

State Registrar

29b. Signature end title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hollarman

3900

DHMH 16 Rev 6/95

1

		For State Registrar	State of Maryla		tificate of L			ag. No. 200	5 0399
Dhysiai	-	1. Decedent's Name (First, Middle, La					2. Date of Deat	th	3. Time of Death
Physicia /Medic		GEORGE	GRE	EEN			FEBRUAL	Day Yea	12400
Examin		4a. Facility Name (If not institution, gi			4b. City, Town, or	Location of Death		4c. County of De	
			ical Center		Baltime			NA	
uneral irector			Sex 7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 6-8-2	Year)	irthplace (State or Forei Country) Md •
*		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limi
e or 28e-f show Le notified at	Director	Md.	NA	•	timore				1X Yes 2 N
Den Den	ă	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	•
s 23e	rai	1635 Hopewell			2122				USA
ral', or Items 23e o	Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 1∆ Yes 2 □ No] It	Vas Decedent of His Yes, specify Cubar		cify Yes or No- Rican, etc.)	Black, Wi	
"natural", idical Esa	ed by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		Yes 2X No			Specify: P	
r than "na the Medic	Completed	(Specify only highest gi Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	kind of work done d OO NOT use retired)	uring most of worki	ng	Tob. Kind of Busines	sylndustry
other ti	Col	12th grade		Cra	ne Operat			Bethleham	Steel
od other	Be	17. Father's Name (First, Middle, Las				18. Mother's Name	(First, Middle, I		
marked o	ဥ	George		een		Carrie		Brown	l
Department of nearing and wents important: if item 27 is marked any injury or other traumatic events.		19a. Informant's Name/Relationship Carolyn Brooks	(Type, Print) Daughter		g Address (Street a. Darthmou			, City or Town, State	, <i>Zip Cod</i> e) 21212
tem		20a. Method of Disposition			sition (Name of natory or other place			20c. Location - City of	
nt: If i		1 Burial 2 Cremation 3 Control			natory or other place Iills Cem.			Middle Ri	
inju		21. Signature of Funeral Service Lice			Name and Address				21202
EEG		1 tomas	/ Gen		arch F.H.	East		. North Av	
ysician and ledical aminer the private and the private aminer	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	A .	quence of):	occlusion's	ion of 1	eft	leg	Approximate Interval Between Onset and Death 4 Aa ys
y the attending pt ached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of d Month	elive <i>r</i> y Day Year
signed by the a d be detached f	by	Part II. Other significant conditions	contributing to death but not re		derlying cause give		_	pacco use contribute	to the cause of death?
s been s	Completed	Depression.	()	Harry	diséa si	J W TO THE STATE OF THE STATE O	24a. Was ar	n 24b. Were	autopsy findings availab
certificate has lirector, page 2 s	Com	Coreners Arkers	Distase				autops perform	ned? death?	completion of cause of
2 5	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only one	э)	
ertil	0	1 ☐ Yes 2 ☐ No	1	ER/Outpatient	3 DOA Other	r. 4 ☐ Nursing Hon	ne 5 Reside	nce 6 Other (Sp	ecify)
his certific	-		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 2	8d. Describe ho	w injury occurred	
ifter this	-	27. Manner of Death 1 🖼 Ratural 5 □ Pending		1		es 2 No			
ifter this	-	1 Accident 3 Suicide 6 Could not be	on 28e. Place of Injury - At h	nome, farm, stre		2	8f. Location (Str	reet and Number or I	Rural Route Number.
fter this	Certification: T	1 Antural 5 Pending 2 Accident 3 Suicide 6 Could not to determined	28e. Place of Injury - At houlding, etc. (Speci	ify)	et, factory, office		City or Town		
fter this	Certification: T	1 Accident 3 Suicide 4 Homicide 5 Pending investigation determined	on 28e. Place of Injury - At h	ify)	occurred at the time	date and place a	City or Town	, State)	no ototod
fter this	-	1 Accident 5 Pending investigation 1 Pen	28e. Place of Injury - At houlding, etc. (Special hysician: To the best of my kn miner: On the basis of examin	ify)	occurred at the time estigation, in my opi	e, date and place, a nion, death occurre number	City or Town	use(s) and manner ate and place, and du	as stated. te to the cause(s)
ifter this	edical Certification: T	1 Aratural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Pending investigatic 6 Could not t determined	28e. Place of Injury - At houlding, etc. (Special hysician: To the best of my kn miner: On the basis of examin	ify)	occurred at the time estigation, in my opi	e, date and place, a nion, death occurre number	City or Town	use(s) and manner ate and place, and du	as stated. te to the cause(s)
ter this neral di	edical Certification: T	1 Aratural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Pending investigatic 6 Could not t determined	28e. Place of Injury - At he building, etc. (Special hysician: To the best of my kn miner: On the basis of examinand manner stated. Aug.	ify) owledge, death ation and/or inv m 23a) (Type, I	occurred at the time estigation, in my opi	e, date and place, a nion, death occurre number	City or Town	use(s) and manner ate and place, and du	as stated. te to the cause(s)

,			1 - For State Registrar		epartment of Health and Certificate of Death	Mental Hygiei	ZUUD UUHHII
	Physici	20	Decedent's Name (First, Middle, Last)	^		2. Date of Death Month	DayMO Year 3. Time of Death
	/Medic			ARDNER.		FEBRUARY	02,2005 9.30 M
	Examin	er	4a. Fecility Name (If not institution, give str		4b. City, Town, or Location of Dea	_	4c. County of Death
			NORTH NEST 5. Social Security Number 6. Sex	HOSPITAL.	TANDALLS fav) If Under 1 Year If Under 24 Hrs		BALTIMORE.
	Funeral Director			4 X□ F 93 Yrs	Months Dave Hours Min		'
	ס		Usual Residence of Decedent				12 MD
	irylan ihow		10a. State 10b. County	10c. City, Town o			10d. Inside City Limits
	8a-f s	cto	MD Baltimo	re Pike	esville		1 ☐ Yes 2 🐴 No
	vith th	Dire	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	e 23e	- La	1840 Reisterstow		21208	Sanaitu Van au Na	U.S.A. 14. Race - American Indian,
40	72 hours after death with the Maryland natural', or Iteme 23a or 28a-f show lited Examinat routh be notified at	Funeral Director	11. Marital Status 1 Never Married 2 Married	. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No	 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 	to Rican, etc.)	Black, White, etc.
036	urs al	by	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Black
5-0036	natur	Completed	15. Decedent's Educa (Specify only highest grade	completed) (C	ecedent's Usual Occupation Give kind of work done during most of wo	orking 16b	. Kind of Business/Industry
21	within ene. than "	nple.	Elementary/Secondary (0-12)	College (1-4or 5+)	fe. DO NOT use retired)		1111
121	filed withi Hygiene. other than	ပိ	10th grade 17. Father's Name (First, Middle, Last)	na S	Seamstress	me (First, Middle, Maid	//VA
Maryland	ould be f I Mental P Parked of Patic eve) Be	Herbert Hines			ne Valent:	
Z	2 shoul and Me Is mark	ဥ	19a. Informant's Name/Relationship (Type	, <i>Print)</i> 19b. N	Mailing Address (Street and Number or F		
	nd 2:		Donna G. Banks-D	aughter 113	Half Moon Bay	Drive, C	roton-on-Hudson
altimore,	es 1 and 2 of Health of item 27 I r other tre		20a. Method of Disposition	20b. Place of D	isposition (Name of crematory or other place)	the same of the sa	. Location - City or Town, State
E	Page nent c nt: If ury or		1 ☐ Burial 2 X Cremation 3 ☐ Rei '4 ☐ Donation 5 ☐ Other (Specify)	noval from State	Crematory Inc.	2/7/05 Ba	altimore, Md
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 Is marked other than "natural; or iteme 23a or 28a-f show any injury or other treumatic event. If a Machical Examiner must be natified at Once.		21. Signature of Forneral Service Licensee	K. Janes	22. Name and Address of Facility March F/H West 4300 Wabash Ave	. Baltimo	ore, Md 21215
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the deeth. Do not			Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	CORONA		ISEASE	Onset and Death
1	/Medical		resulting in death)	Due to (or as a consequence of)		1301130	
	Examiner		Sequentially list conditions, b.			FAILURG	
1/	ed isit	Examiner	Sequentially list can dians, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of)			
V	be execut ician and burial-trar	xan	that initiated events c. resulting in death) Last	Due to (or as a consequence of):	IAL FBRILLAT	I DIM .	
8760	cate be executed physician and the burial-transit	dical E	d				
9	g physias the	edic	0.				
Вох	The law requires that the death certifics tte has been signed by the attending ph page 2 should be detached for use as t	Physician/Med	23b. was decedent pregnant	If yes, outcome of pregnancy	3 Ectopic pregnancy		23d. Date of delivery
	e deat	sicia	in the past 12 months?	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)		Month Day Year
P.0	res that the de signed by the a to be detached f	Phy	9 Unknown '			On Didashara	
	signe bed	by	Part II. Other significant conditions contr	buting to death but not resulting in th	ie underlying cause given in Part i.	1 Tes	co use contribute to the cause of death? 2 No 3 Probably 4 Munknown
OC	w require	Completed				:	/
360	has has ge 2 s	mp				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
a			OF Was once referred to modical			1 ☐ Yes 2 🗖	
₹	Physician: The law this certificate has be ral director, page 2 s	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 1 Inpatient 2 ER/Outpa	Other	ath (Check only one) Home 5 Residence	6 Othor (Specific)
of	g Phy er this	n: To	27. Manner of Death	28a. Date of Injury 28b. Tim	ne of 28c. Injury at	28d. Describe how in	
ion	Attending r death. ector: After by the funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Inju	M 1 Yes 2 No		
Division of Vital Records,	r Atte er de: recto by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number,
	itel or ris aft rel Di			3, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Exemine	ian: To the best of my knowledge, or: On the basis of examination and/or and manner stated.	leath occurred at the time, date and place or investigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	ellam.o	29c. License number		Date signed (Month, Day, Year)
•	1		- Frankon		D41410		zualy 2 " 2005.
	ク		30. Name and address of person who com	^	20011100		0.4
			31. Date filed (Month, Dar Mear) 1 2	PITITU (ENTER	RANGE TOWN	mo 2	11.22
	Sta Registr		FEB 1 0 2	00532. Reoff Are Signature			